

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03774

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

3828

1. PLACE OF DEATH  
a. COUNTY

Talbot

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE new york

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

New York

69X-3

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

EASTON

c. LENGTH OF STAY IN lb

50 min.

d. STREET ADDRESS

252 W. 149 St.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Memorial Hospital

e. IS RESIDENCE  
ON A FARM?

YES  NO

3. NAME OF  
DECEASED  
(Type or print)

Thomas

First

Middle

Last

4. DATE  
OF  
DEATH

MAR 11

1960

5. SEX

Male

6. COLOR OR RACE

Col

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

10/3/92

9. AGE (In years  
last birthday)

67 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Fireman

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Ancrum

14. MOTHER'S MAIDEN NAME

Unknown

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

124-03-1135

17. INFORMANT

Rosalie Ancrum

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

592X

DUE TO

Wrenna

INTERVAL BETWEEN  
ONSET AND DEATH

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Ch. respiratory

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour  
a. m. —  
p. m. 19

20d. INJURY OCCURRED  
While at work  Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes  Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE *Lewis Wherry* DATE SIGNED

EXAMINER'S NAME (Type)

*W.E.T.Y.*

M.D. CHIEF MEDICAL EXAMINER   
ASSISTANT MEDICAL EXAMINER   
DEPUTY MEDICAL EXAMINER

3-12-60

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

22b. DATE THEREOF

3/16/60

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

New York

n.y.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

*James B. Marshall, Easton, Md.*

24a. REC'D BY REGISTRAR

MAR 23 '60

DATE

24b. REGISTRAR'S SIGNATURE

*Carine S. Krause*

DEATH CERTIFICATE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE ID:  
TRENTON

NAME:  
WILLIAM J. CONNELLY

ADDRESS:

101 E. 12TH ST., NEW YORK CITY

PHONE NUMBER:

(212) 537-1234

AGE:

65

SEX:

MALE

RACE:

WHITE

ETHNICITY:

IRISH

RELIGION:

CATHOLIC

EDUCATION:

GRADE 12

EMPLOYMENT:

UNEMPLOYED

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

DEATH DATE:

APRIL 15, 1998

TIME OF DEATH:

11:00 AM

CAUSE OF DEATH:

HEART DISEASE

DEATH PLACE:

HOSPITAL

DEATH NUMBER:

1234567890

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03775

## CERTIFICATE OF DEATH

Reg. Dist. No.

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		3829	CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY		Talbot			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		Reg. Dist. No.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Easton			c. LENGTH OF STAY IN lb			a. STATE Maryland		b. COUNTY Queen Anne			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Memorial Hospital			7 mos.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		rural Queen Anne 17X-2			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					d. STREET ADDRESS								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year				
Male		White	WIDOWED <input type="checkbox"/>	Divorced <input type="checkbox"/>	FEB. 26, 1887		93 yrs.	8	1960	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
farmer				Maryland		U.S.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address									
Elmer E. Andrew		Tacey Johnson		Mr. Lee Andrews Easton, Md.									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH				
(If yes, give war or dates of service)		220-18-6325				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)							
500x						acute bronchitis							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		{ (b)		DUE TO		Coronary insufficiency							
{ (c)													
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 6:30 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED					
ACTUAL SIGNATURE		E. C. Schmidt		M.D. 2195 Washington St. 9 March 60									
PHYSICIAN'S NAME (Type)		E. C. Schmidt		E. C. Schmidt		E. C. Schmidt		E. C. Schmidt		E. C. Schmidt			
22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)					
Burial		Mar. 11, 1960		Toring Hill Cemetery		Easton, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
Malvina E. Newnam & Son		Easton, Md.		DATE MAR 11 '60		C. W. Newnam							

INTAKE NO. 37439120

100%

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 could be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

V.S. A15M  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3839 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>TALBOT</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	b. COUNTY <i>TALBOT</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>	c. LENGTH OF STAY IN 1b <i>2 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>	d. STREET ADDRESS <i>S. Aurora St.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>S. Aurora St.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>CHARLIE</i>	First <i>Barwick</i>	Middle <i>Barwick</i>	Last <i>MARCH 12 1960</i>	
4. DATE OF DEATH <i>JAN. 9 1899</i>	Month <i>61 yrs.</i>	Day <i>Months Days Hours Min.</i>	Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>1899</i>	
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years from birthday) <i>61 yrs.</i>		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>FARMING</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>FRANK</i>	14. MOTHER'S MAIDEN NAME <i>ICA</i>	Address <i>9 JUDAS ST. EASTON, MD</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>242-16-1980</i>	17. INFORMANT <i>MR. JAMES R. PATRICK</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Status asthmaticus</i>	
241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>Louis S. WELTY</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>3-14-60</i>		
EXAMINER'S NAME (Type) <i>Louis S. WELTY, M.D.</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>3/15/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>SPRING HILL</i>	22d. LOCATION (City, town, or county) (State) <i>EASTON, MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joe Taylor, Cawell, Easton, Md.</i>	ADDRESS <i>100 High St., Easton, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>MAR 21 '60</i>	24b. REGISTRAR'S SIGNATURE <i>John S. Trahan</i>	

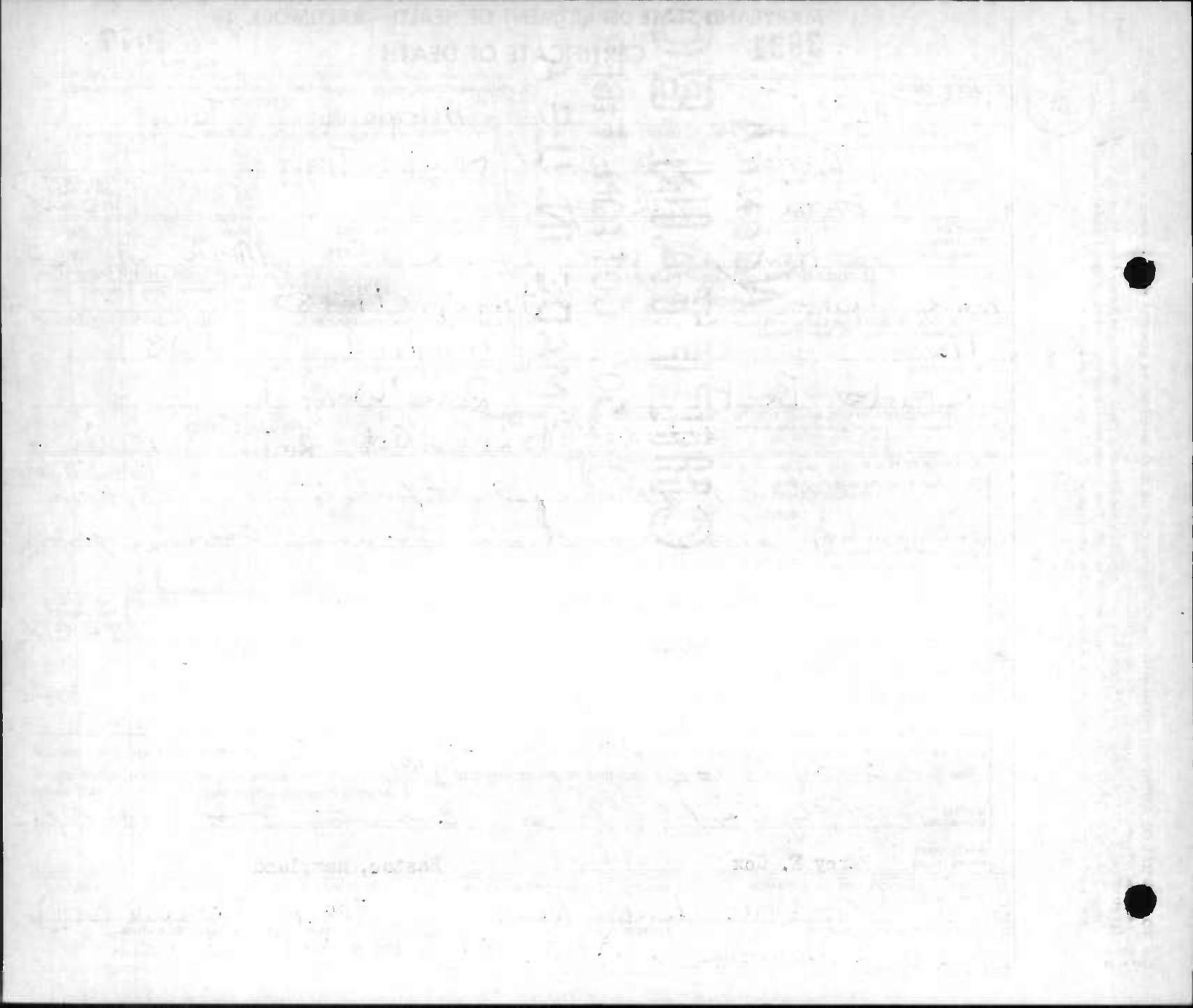


1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3831 CERTIFICATE OF DEATH

Reg. Dist. No. 4977

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>2 hrs 25 min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henry W. Beck</u>		First	Middle
		Last	4. DATE OF DEATH <u>March 31 1960</u>
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH <u>July 5 1879</u>		9. AGE (In years lost birthday) <u>80</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) <u>Maryland</u>		11. CITIZEN OF WHAT COUNTRY? <u>S.S.</u>	
13. FATHER'S NAME <u>Charles Beck</u>		14. MOTHER'S MAREN NAME <u>Rosa Weinrich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-05-5370</u> INFORMANT <u>Mrs. Linwood Cox</u> Address <u>MA 26th Street Richmond 26 Va</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial Infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Coronary Disease</u> 2 yr			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Easton</u> (County) <u>MD</u> (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>Dept. 20, 1959</u> to <u>3/31/1960</u> that I last saw the deceased alive on <u>3/31/1960</u> , and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton, Maryland</u> DATE SIGNED <u>4/1/60</u>			
ACTUAL SIGNATURE <u>Percy R. Cox</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>Percy R. Cox</u>		EASTON, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 2, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Landing Neck</u>		22d. LOCATION (City, town, or county) <u>Trappe Maryland (rural)</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Neumann</u>		ADDRESS <u>Easton, Md.</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Thoms</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	
DATE <u>APR 6 '60</u>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3832

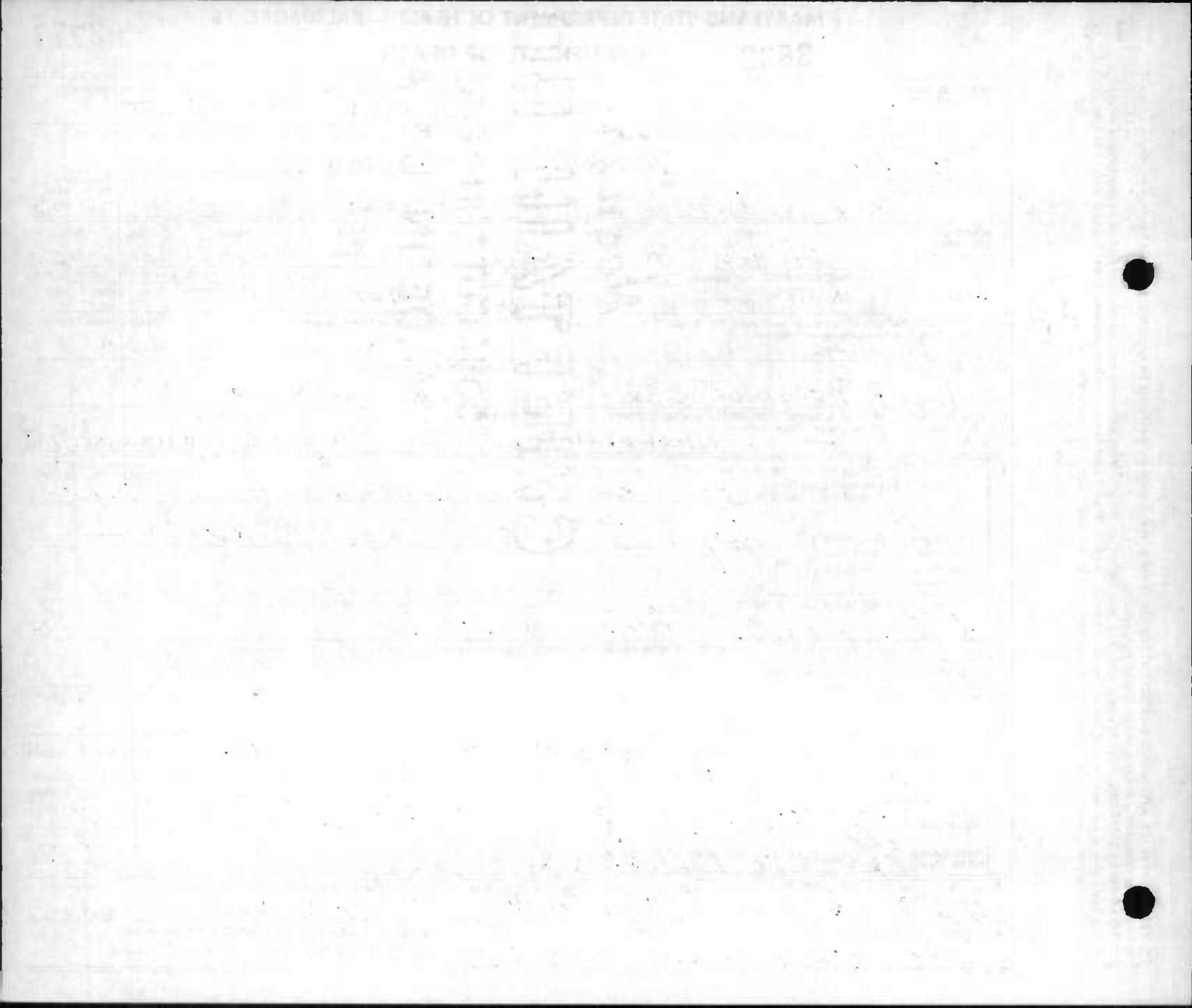
## CERTIFICATE OF DEATH

Reg. Dist. No.

03777

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		c. LENGTH OF STAY IN 1b <i>7 mo 25 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X NEWCOMB</i>		d. STREET ADDRESS <i>1 RURAL</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i>				d. STREET ADDRESS <i>1 RURAL</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Sidney R Bedsworth</i>		First	Middle	Last	4. DATE OF DEATH Month <i>March</i>	Day <i>10</i>	Year <i>1960</i>
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 27 1904</i>		9. AGE (In years lost birthday) 55 yrs. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>City Employee</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>ROYAL OAK MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>SIDNEY R BEDSWORTH SR</i>		14. MOTHER'S MAIDEN NAME <i>LULA FAULKNER</i>				Address <i>Mrs. Ethelie Marshall, Newent. 2nd</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-01-0201</i>		INFORMANT <i>Mrs. Ethelie Marshall, Newent. 2nd</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral hemorrhage</i> DUE TO <i>331X</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension Essential Vas</i> DUE TO <i>dihydroxybenzenevas. d</i> (c) <i> </i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i> </i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i> </i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i> </i>	
21. I certify that I attended the deceased from <i>3-10-1960</i> , to <i>3-10-1960</i> , that I last saw the deceased alive on <i>3-10-1960</i> , and that death occurred at <i>11:45 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city, or town, state) <i>St. Michael's Md</i> DATE SIGNED <i>3-11-60</i>							
ACTUAL SIGNATURE <i>George Reeder</i>		M.D. <i>George Reeder</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-15-60</i>	
PHYSICIAN'S NAME (Type) <i>George Reeder</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Olive Cemetery</i>		22d. LOCATION (City, town, or county) <i>St. Michael's Md</i>		(State) <i> </i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Hamilton Harrison, St. Michael's Md</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>MAR 14 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Conrad S. Kraus</i>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03778

Reg. Dist. No.

3833

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please state the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 could be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal; and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD</b>		b. COUNTY <b>Talbot</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X TRAPPE</b>		d. STREET ADDRESS <b>1</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>THOMAS W BLADES</b>		First	Middle	4. DATE OF DEATH <b>APR. 24, 1882</b>	Month <b>3</b>	Doy <b>8</b>	Year <b>1960</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR. 24, 1882</b>	9. AGE (In years from birthday) <b>77 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>THOMAS J. BLADES</b>		14. MOTHER'S MAIDEN NAME <b>CARRIE M. ADAMS</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-16-7644</b>		17. INFORMANT <b>Mrs Myrtle Bryan</b>		Address <b>Easton, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		COPROKSY OCLUSION				INTERVAL BETWEEN ONSET AND DEATH <b>Immmed.</b>		
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  DUE TO (b)  DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <b>4:30 p.m.</b>		Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>EASTON</b>	(County) <b>MD.</b>	(State) <b>MD.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Louis P. Welty</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3-8-60</b>		
EXAMINER'S NAME (Type) <b>WELTY</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL MAR. 11, 1960</b>		22b. DATE THEREOF <b>MAR. 11, 1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>SPRINGHILL CEM.</b>		22d. LOCATION (City, town, or county) <b>EASTON</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>		ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thorne</b>		

BY DIRECT MAIL - IT APPROVED BY THE STATE OF KANSAS  
HANCOCK STADLER & MAXWELL, ATTORNEYS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3834

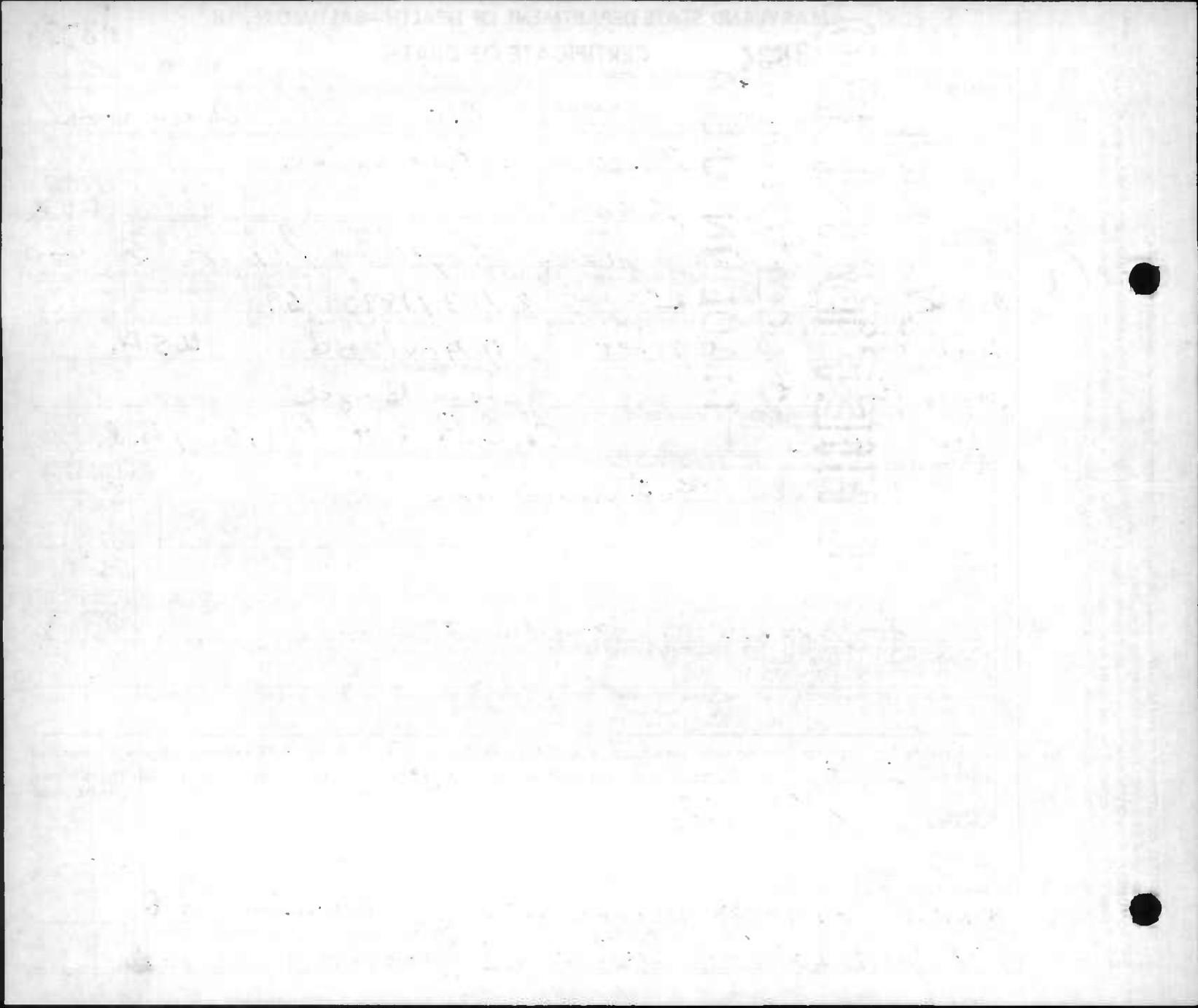
## CERTIFICATE OF DEATH

Reg. Dist. No.

03779

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Talbot</i>		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<i>Easton</i>		<i>2 hours</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Memorial Hospital</i>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Noah James Joyce</i>		<i>Noah</i>	<i>James</i>
4. DATE OF DEATH		Month	Day
		<i>March</i>	<i>6</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>Male</i>		<i>Col</i>	
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR IF UNDER 24 HRS.
		<i>8/13/1890</i>	69 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Labrador</i>		<i>Oyster</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Maryland</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>James Ridout</i>		<i>Sara Boyce</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
<i>Yes</i>		<i>WWI</i>	
17. INFORMANT		Address	
<i>Carl Pinkett, Chester, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Atherosclerosis</i>	
<i>450.0</i>		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)	
		DUE TO	
		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Exposure &amp; malnutrition</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3/5/60</i> , 1960, to <i>3-60</i> , 1960, and that death occurred at <i>1/1/60</i> AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>B. Col</i>		M.D. _____	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial</i>		<i>3/13/60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
<i>Vernon Cemetery</i>		<i>Vernon, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<i>James B. Darrell, Easter, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	
ADDRESS		DATE <i>MAR 15 '60</i>	



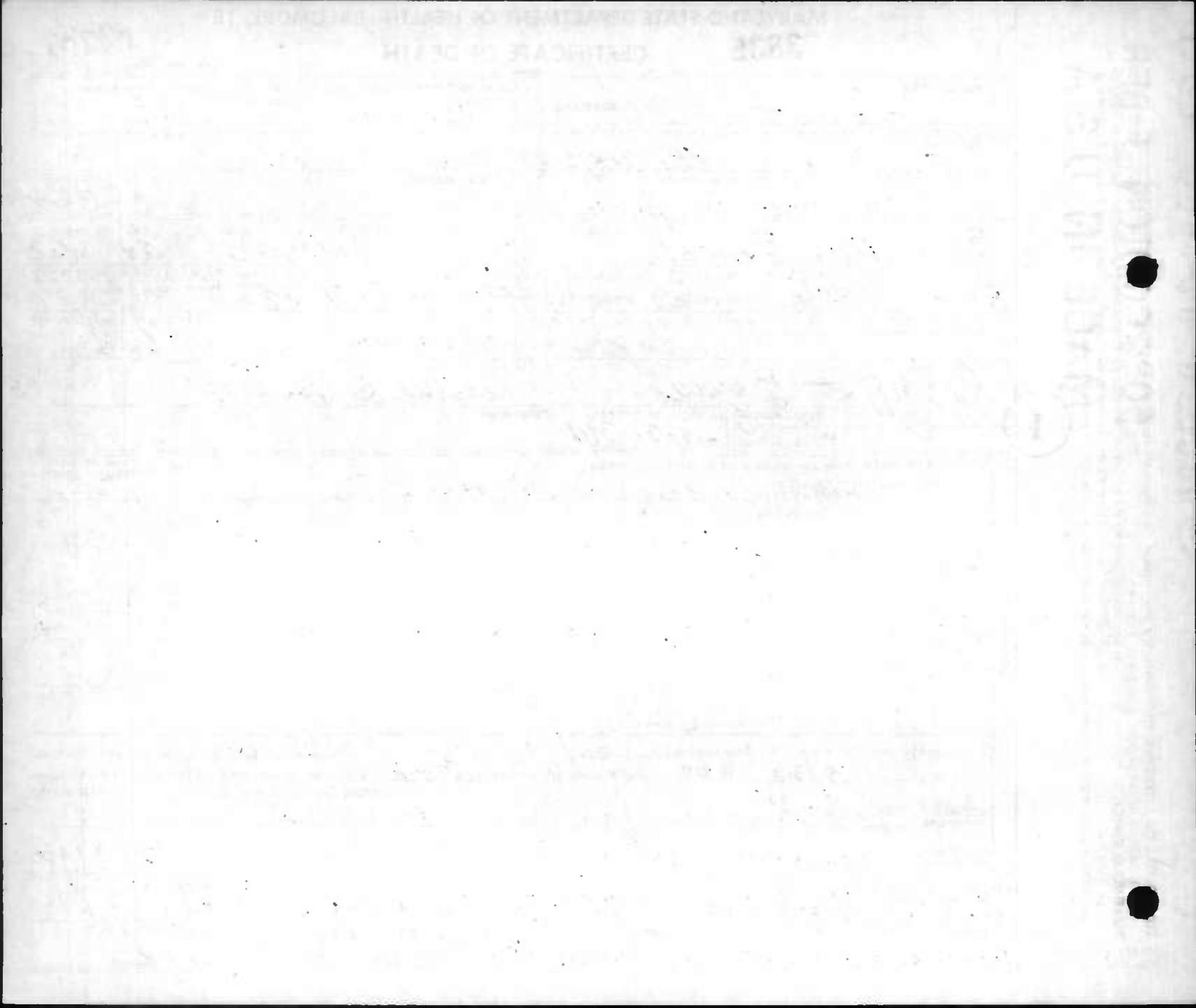
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3835 CERTIFICATE OF DEATH

Reg. Dist. No.

03781

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		b. COUNTY		Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		x Rural Trappe		d. STREET ADDRESS				
c. LENGTH OF STAY IN 1b		47 days.		d. STREET ADDRESS								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year				
Male		white		Bryan	March	29	1960					
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.					
				19 JUNE 5, 1897	82 yrs.		Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?						
Laborer				Maryland		U.S.A.						
13. FATHER'S NAME		14. MOTHER'S MIDDLE NAME										
Robert F. Bryan		Aurie E. Hastings										
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year of dates of service)		INFORMANT		Address						
No		219-34-3901										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease YES DUE TO 420.0												
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Generalized arteriosclerosis YES DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Second & Third degree burns, rt. leg.												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2/12, 1960, to 3/28, 1960, that I last saw the deceased alive on 3/28, 1960, and that death occurred at 1:35A.M. from the causes and on the date stated above.												
ADDRESS (Street, city or town, state) EASTON DATE SIGNED 3/29/60												
ACTUAL SIGNATURE Shearer Jr. PHYSICIAN'S NAME (Type) Shepard Grech Jr. M.D. Md. 3/29/60												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 31, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Wimpy Hill Cemetery		22d. LOCATION (City, town, or county) Easton (Rural) Md. (State)						
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Neumann Son		ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE APR 1 '60		24b. REGISTRAR'S SIGNATURE Charles S. Thomas						



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3836

## CERTIFICATE OF DEATH

Reg. Dist. No.

03780

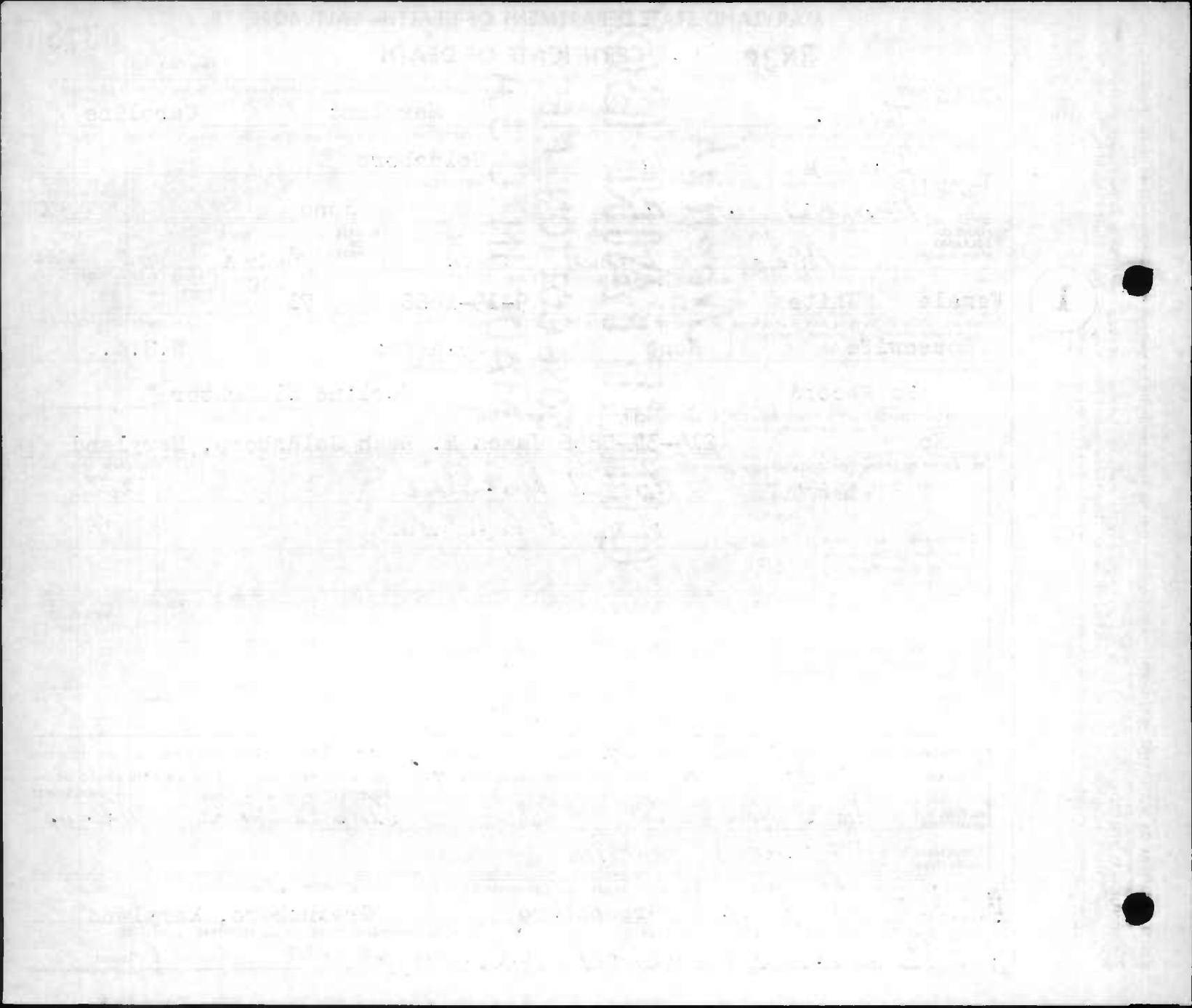
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Alice</i>	Middle <i>Edna</i>	Last <i>Bush</i>
4. DATE OF DEATH <i>March 10 1960</i>	Month <i>March</i>	Day <i>10</i>	Year <i>1960</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-19-1888</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Delaware</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>No Record</i>		14. MOTHER'S MAIDEN NAME <i>Carline Slaughter</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>214-34-8856</i>	INFORMANT <i>James M. Bush Goldsboro, Maryland</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>36 hr.</i> (?)	
DUE TO <i>Cerebral hemorrhage</i> Cerebral hemorrhage Cerebral hypertension			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>9 AM</i> , 19 <i>60</i> , to <i>10 AM</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>10 Mar</i> , 19 <i>60</i> , and that death occurred at <i>4P</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Arthur Mayland</i>	
ACTUAL SIGNATURE <i>Thurston Harrison</i>		DATE SIGNED <i>11 Mar 60</i>	
PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-14-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Greensboro</i>	22d. LOCATION (City, town, or county) (State) <i>Greensboro, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Bouleau Greensboro, Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>MAR 14 '60</i>
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

Hospital or attending physician:  
be retained by the hospital or attending physician.

To Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

24 hours after death. Page 4



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G260  
4/13/60 2wk  
3837

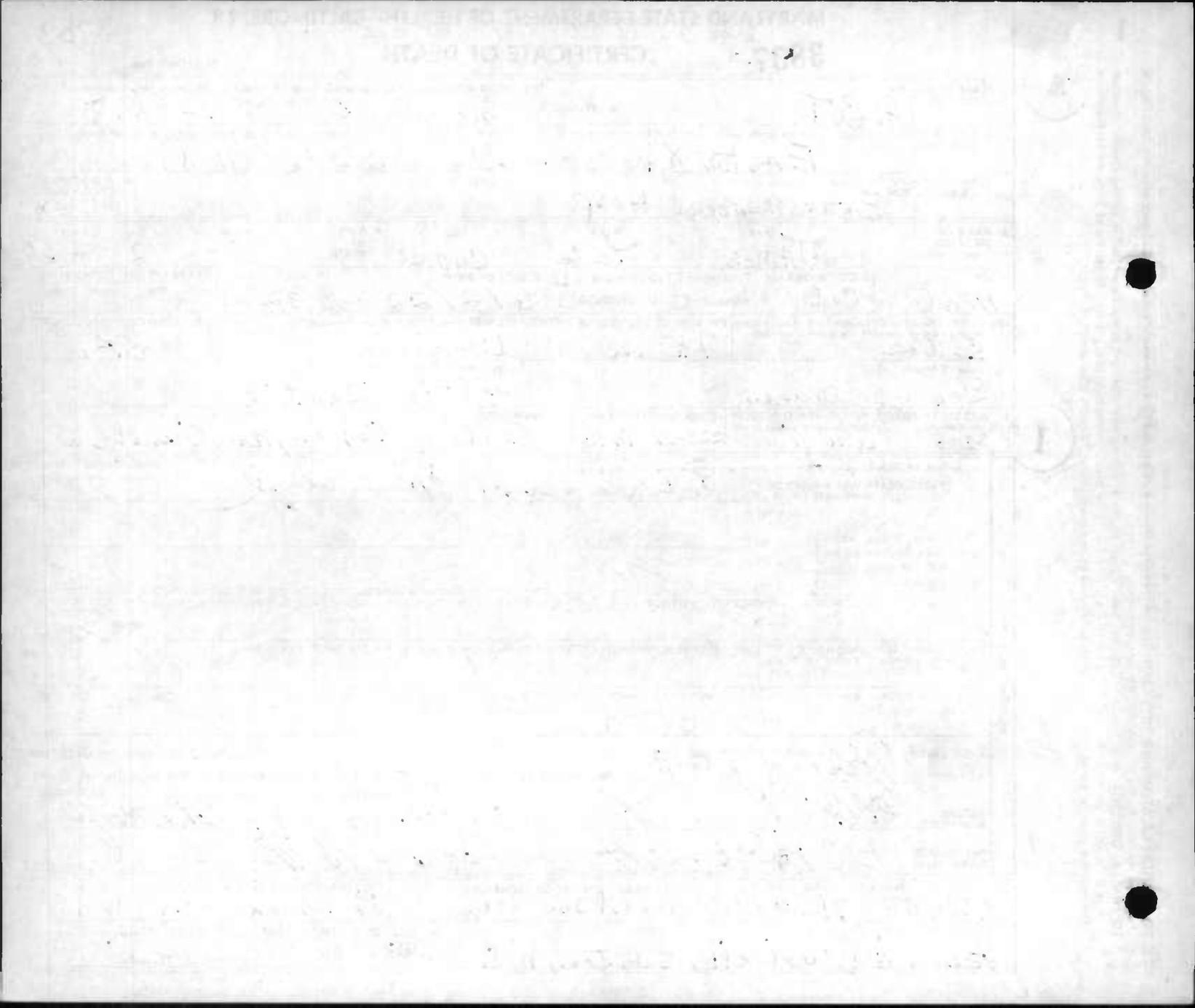
## CERTIFICATE OF DEATH

Reg. Dist. No.

03782

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		2		3	
1. PLACE OF DEATH a. COUNTY <b>TALBOT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		3. NAME OF DECEASED (Type or print) <b>James Lewis Copes</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON 8 hrs 35 min</b>		c. LENGTH OF STAY IN 1b <b>RURAL</b>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glasgowville, Md. 17X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTON Memorial Hosp.</b>		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>James</b>	Middle <b>Lewis</b>	Last <b>Copes</b>	4. DATE OF DEATH Month <b>3</b> Day <b>12</b> Year <b>1960</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6/12/22</b>	9. AGE (In years last birthday) <b>37 1/2 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Copes</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Seattle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>227-24-1690</b>		INFORMANT <b>Sillian Copes, New Church Va</b>	
17. INTERVAL BETWEEN ONSET AND DEATH		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial Hemorrhage</b>		DUE TO (b) <b>33IX</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>DUE TO</b>		(c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month <b>Mar</b> , Day <b>19</b> , Year Hour <b>a. m.</b> <b>19</b> <b>p. m.</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>(County) (State)</b>	
21. I certify that I attended the deceased from <b>alive</b> on <b>19</b> , 19 <b>60</b> , to <b>19</b> , 19 <b>60</b> , that I last saw the deceased and that death occurred at <b>10A M</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>M.D. 2195 Washington St, Easton, Md.</b>	
ACTUAL SIGNATURE <b>E.C.H. Schmidt</b>				DATE SIGNED <b>6/15/60</b>	
PHYSICIAN'S NAME (Type) <b>E.C.H. Schmidt</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>3/20/60</b>		22b. DATE THEREOF <b>3/20/60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Wardour Cem.</b>	
22d. LOCATION (City, town, or county) <b>Easton City, Md.</b>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Dashfield, Easton, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>Mar 23 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3838

## CERTIFICATE OF DEATH

64980

Reg. Dist. No.

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTON Memorial Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MRS. Beulah MAY</b>	First	Middle	Last <b>Creamer</b>
4. DATE OF DEATH <b>3 - 11 1960</b>	Month	Day	Year
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 16 1895</b>
9. AGE (In years last birthday) <b>64 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWORK</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>WILLIAM HENRY COX</b>	14. MOTHER'S MAIDEN NAME <b>BELL</b>	Address <b>5, PARK ST., EASTON, MD.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	INFORMANT <b>Mrs. HENRY Parks,</b>	INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>540.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bleeding Postpartum</b> DUE TO <b>Stomach Therapy</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Osteoarthritis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. m.</b> <b>p. m.</b>	Month <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>EASTON</b> (County) <b>MARYLAND</b> (State) <b>MARYLAND</b>
21. I certify that I attended the deceased from <b>1946</b> , to <b>3/11/1960</b> that I last saw the deceased alive on <b>3/11/1960</b> , and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>P. E. Cox</b>	M.D. <b>P. E. Cox</b>		ADDRESS (Street, city or town, state) <b>EASTON, MD.</b>
PHYSICIAN'S NAME (Type) <b>P. E. Cox</b>	DATE SIGNED <b>3-11-60</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/14/60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>GREEN LAWN</b>	22d. LOCATION (City, town, or county) <b>CAMBRIDGE MD.</b> (State) <b>MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joe Hampton Carroll</b>	ADDRESS <b>EASTON, MD.</b>	24a. REC'D BY REGISTRAR <b>DEPR 19 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>

540.0

Item 9 FilmG261 4-21-60 et

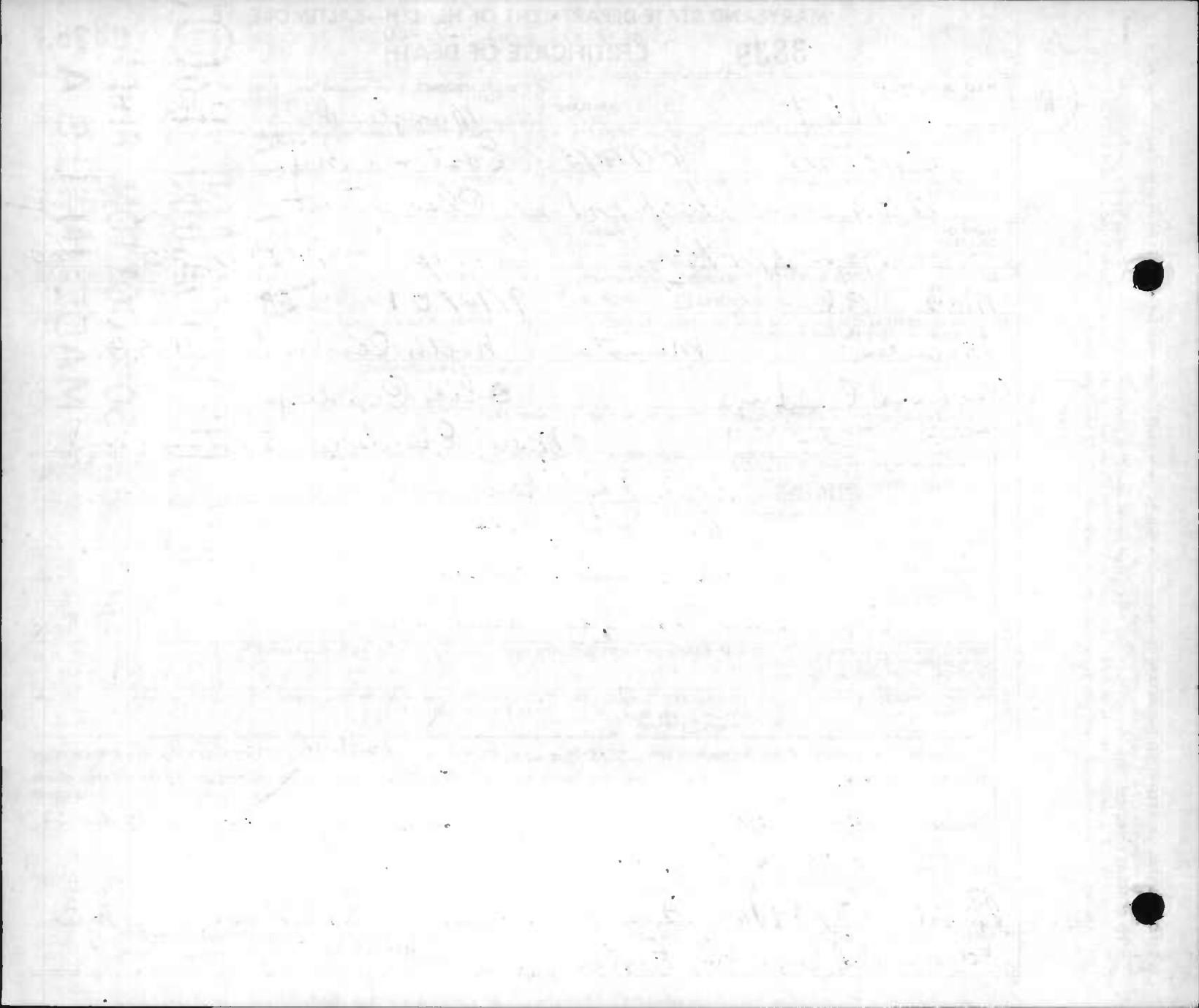
03783

**Reg. Dist. No.**

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed while it is being retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

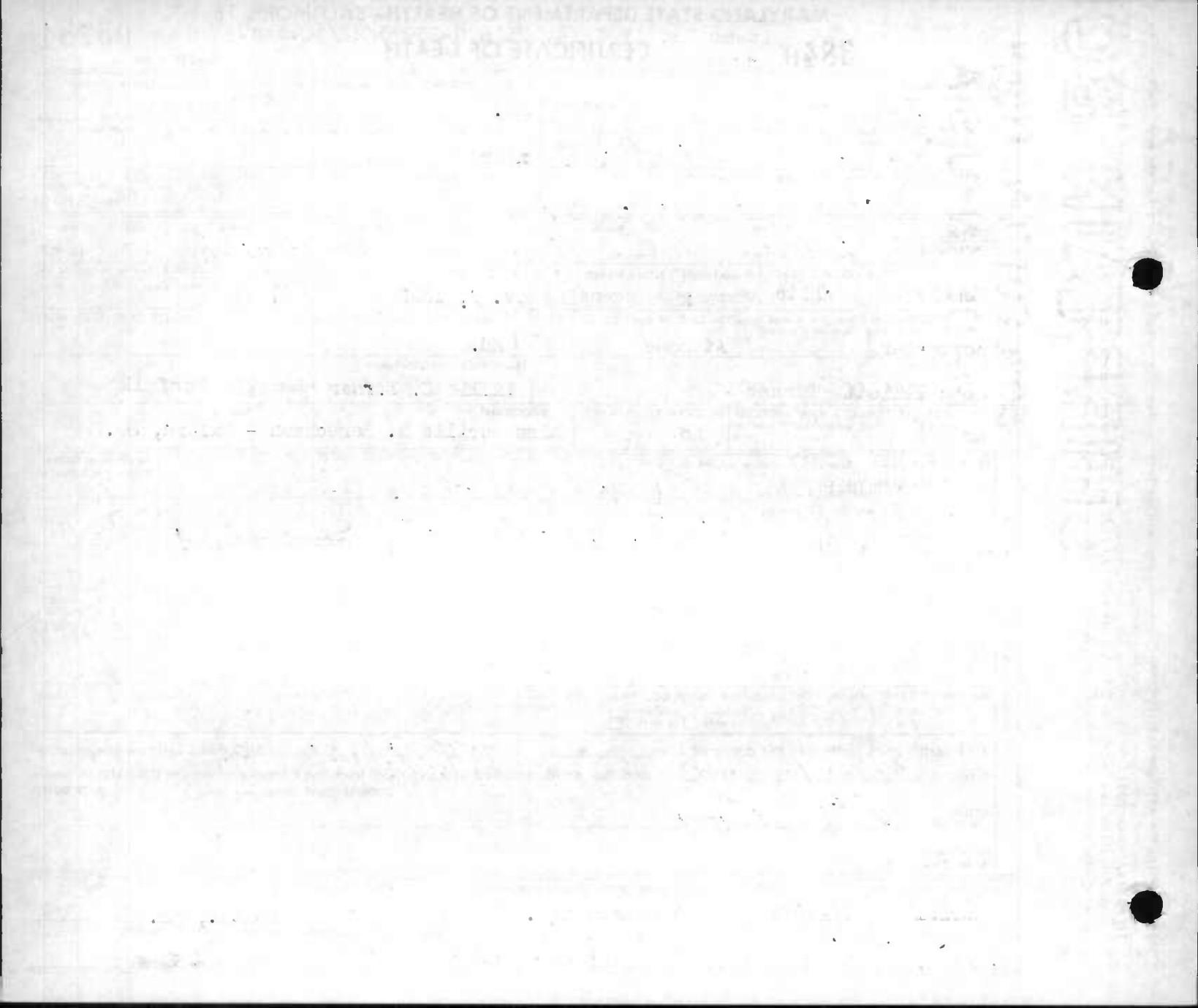
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Talbot</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>6 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>408 Easton, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>			d. STREET ADDRESS <i>1 Clay Street</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Rev. Fredsey</i>		First <i>F</i>	Middle <i></i>	Lost <i></i>	Date Month <i>March 15</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>9/12/01</i>	9. AGE (In years lost birthday) <i>58 59 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Minister</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Minister</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	
13. FATHER'S NAME <i>Richard Crudey</i>			14. MOTHER'S MAIDEN NAME <i>Alia Crudey</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i></i>			16. SOCIAL SECURITY NO. <i></i>		
INFORMANT <i>Mary Crudey Easton, Md.</i>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteria &amp; lymphaticum</i> DUE TO <i>608X</i> INTERVAL BETWEEN ONSET AND DEATH <i>2060.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic pyelonephritis</i> ? (c) <i>Chronic urthral stricture</i> ?					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>ACVD, cardiac hypertrophy, cardiac failure</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9 Mar</i> , 19 <i>60</i> , to <i>15 March</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>14 Mar</i> , 19 <i>60</i> , and that death occurred at <i>Hospital</i> , M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Thurston Harrison</i>			ADDRESS (Street, city or town, state) <i>Acton, Maryland</i>		
PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>			DATE SIGNED <i>15 Mar 60</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/19/60</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Green Acre Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Baltimore</i>			(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Blodhill, Easton, Md.</i>			ADDRESS <i></i>		
24a. REC'D BY REGISTRAR <i>MAR 23 '60</i>			24b. REGISTRAR'S SIGNATURE <i>Cintra S. Frantz</i>		



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page \_\_\_\_\_  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 Items 1c, 13 & 14, Film G-259 3/22/60.cac.  
**CERTIFICATE OF DEATH**  
 Reg. Dist. No. 03784  
 3840

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		c. LENGTH OF STAY IN 1b <i>9 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Memorial Hosp</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oxford</i>	
3. NAME OF DECEASED (Type or print) <i>Lillie</i>		d. STREET ADDRESS <i>1</i>	
4. DATE OF DEATH <i>MARCH 13 1960</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 3, 1862</i>
9. AGE (In years last birthday) <i>97 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>	11. KIND OF BUSINESS OR INDUSTRY <i>At home</i>	12. BIRTHPLACE (State or foreign country) <i>Md.</i>
13. FATHER'S NAME <i>John E. Turner</i>	14. MOTHER'S MAIDEN NAME <i>Katherine Cecelia Norfolk</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>no</i>	INFORMANT <i>Miss Cecilia N. Eareckson - Oxford, Md.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>446X</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Nephrosclerosis</i>			
DUE TO (c) <i>Arteriosclerosis, generalized</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>?</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____ to _____, 19____, and that death occurred at _____, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Cope</i>			ADDRESS (Street, city or town, state) DATE SIGNED
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/16/60</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Baltimore Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Tichner &amp; Sons Math &amp; Penalties</i>		ADDRESS <i>100 W. Pratt Street Baltimore Md.</i>	24a. REC'D BY REGISTRAR DATE <i>MAR 15 '60</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Tamm</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3841

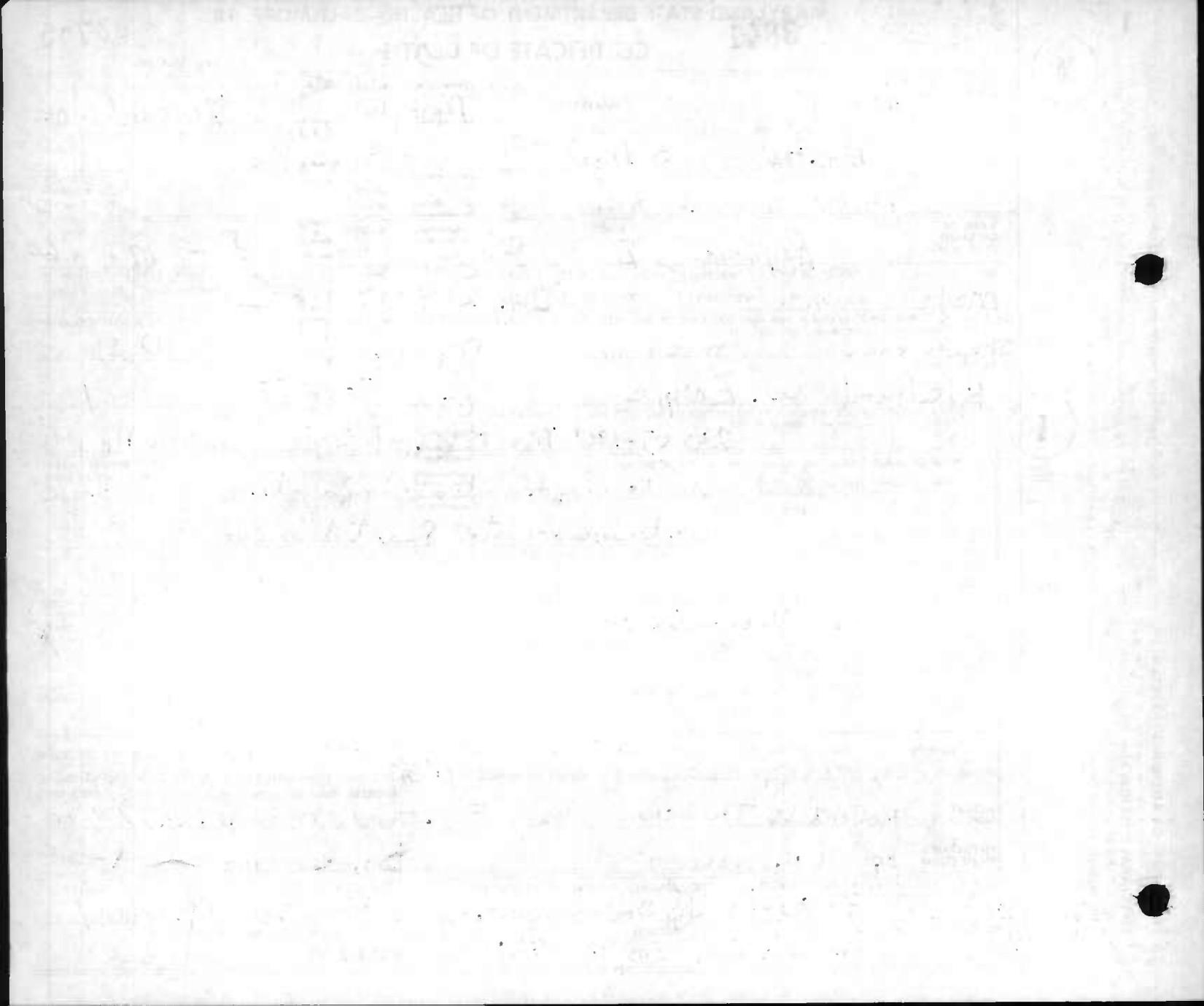
## CERTIFICATE OF DEATH

Reg. Dist. No.

03785

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) <b>Maryland</b>		b. COUNTY <b>Gulden Anne</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Centreville</b>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton Memorial Hosp.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Raymond D.</b>		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>July 24 1907</b>	9. AGE (In years last birthday) <b>52</b>	IF UNDER 1 YEAR YES	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipfitterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>mechanic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Richard W. Engle</b>		14. MOTHER'S MAIDEN NAME <b>Ebbie Jeerist</b>		Address <b>220 09-13C7 Mr. Raymond Engle Centreville Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Acute myocardial infarction</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Arteriosclerotic heart disease</b> ?									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Easton</b>		(County) <b>Maryland</b>	(State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>3/12</b> , 19 <b>60</b> , to <b>3/17</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>3/17</b> , 19 <b>60</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>Easton, Maryland</b>									DATE SIGNED <b>3/19/60</b>
ACTUAL SIGNATURE <b>Robert W. Trever</b>		M.D.							
PHYSICIAN'S NAME (Type) <b>Robert W. Trever</b>		Easton, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-20-60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Jr. Order Cemetery</b>		22d. LOCATION (City, town, or county) <b>Preston Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Neuram &amp; Son</b>		ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR <b>Marie S. Kraus</b>		24b. REGISTRAR'S SIGNATURE <b>Marie S. Kraus</b>			
VS A15 (4) 15M 9/5B				DATE <b>MAR 22 '60</b>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03786

FOR STATE  
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please initial the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
To FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		3866										2			
M												X			
I												O			
2															
VS. A15ME SM 2/57															
1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE					
<i>Talbot</i>		<i>Sherwood</i>				<i>Life</i>				<i>Maryland</i>					
MARYLAND										b. COUNTY					
										<i>Talbot</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<i>Box 16</i>															
3. NAME OF DECEASED (Type or print)		First		Middle		Lost		4. DATE OF DEATH		Month		Doy		Year	
<i>Charles Douglass</i>								<i>GRACE</i>		3		16		19 60	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH		9. AGE (in years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.			
<i>Male</i>		<i>Cot</i>		<i>WIDOWED <input checked="" type="checkbox"/></i>		<i>11/26/1876</i>		<i>83</i> yrs.		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
<i>Laborer</i>		<i>Retired</i>		<i>Maryland</i>		<i>U.S.A.</i>									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
<i>George Grace</i>		<i>Clara Whittington</i>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
						<i>Sittleton Grace, Sherwood, Md.</i>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Chronic glaucoma</i>													
<i>420.1</i>		<i>Arterial sclerosis</i>													
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b)															
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
<i>Velodactyly</i>		<i>5 years</i>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		<i>John M. Reeser Jr.</i>										DATE SIGNED			
EXAMINER'S NAME (Type)		<i>John M. REESER Jr.</i>													
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM				22d. LOCATION (City, town, or county)		(State)					
<i>Burial</i>		<i>3/10/68</i>		<i>Sherwood Cem.</i>				<i>Sherwood</i>		<i>Md.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
<i>James Dashiell, Easton, Md.</i>						<i>MAR 23 '68</i>		<i>John S. Tracy</i>							
DATE															

WEIGHTS AND MEASURES COMMISSION OF CALIFORNIA  
STATE DEPARTMENT OF MINE - SALTINOS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3867

## CERTIFICATE OF DEATH

Reg. Dist. No.

03788

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copy from papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Neavitt		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Neavitt			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				d. STREET ADDRESS 1 -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First MARY	Middle I.	Last KOERNER	4. DATE OF DEATH	Month March 13,	Day Year 1960
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1898</b>	9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Uniontown, Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Gray</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Cole</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. -----		INFORMANT <b>Eugene Koerner, Neavitt, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, immediate</b> <b>420.1</b> DUE TO (b) <b>atherosclerotic obstructive</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (c) <b>coronary artery d</b> DUE TO - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-16</b> , 19 <b>63</b> , to <b>3-13</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6-30-58</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Guy M. Reeser Jr., M.D.</b> DATE SIGNED <b>3-15-60</b> ACTUAL SIGNATURE <b>GUY M. REESER, JR., M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 16, 1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>St. Michaels, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Hampton Garrison, St. Michael's</b>				ADDRESS <b>ne</b>		24a. REC'D BY REGISTRAR <b>DAT MAR 17 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>

ITACO STATION

1000

X

100

1000

old DNA work

new sample

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3842

## CERTIFICATE OF DEATH

Reg. Dist. No.

03789

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b>		b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Tilghman</b>		d. STREET ADDRESS <b>'Aralon Post Office</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Hannah</b>	Middle <b>M.</b>	Last <b>Larrimore</b>	4. DATE OF DEATH Month <b>MAR</b>	Month <b>25</b>	Day <b>19</b>	Year <b>60</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>w</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 6 1894</b>	9. AGE (In years last birthday) <b>66 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>MR. JAMES Rambo</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Middleton</b>		INFORMANT <b>Edward Larrimore Aralon Md</b>		Address <b>Arlon Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac failure</b> - DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerotic coronary artery d</b> - DUE TO (c) <b>-</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>uremia-Terminal cachexia-severe</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 14, 1960</b> to <b>March 25, 1960</b> , that I last saw the deceased alive on <b>3-25-60</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Myself</b> M.D. ADDRESS (Street, city or town, state) <b>St. Michaels Md</b> DATE SIGNED <b>3-25-60</b>							
PHYSICIAN'S NAME (Type)		<b>Dr. Guy M. Reeder</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>3-28-60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Tilghman County</b>		22d. LOCATION (City, town, or county) (State) <b>Tilghman 2nd</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Hampton Harrison, St. Michaels Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>DAT MAR 30 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Thoms</b>	



FOR STATE  
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3843 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03790

Reg. Dist. No.

1	1. PLACE OF DEATH o. COUNTY <b>Talbot</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b>							
M	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>	b. COUNTY <b>Talbot</b>							
X	c. LENGTH OF STAY IN lb <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HOB EASTON</b>							
I	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>108 Hammond</b>	d. STREET ADDRESS <b>108 Hammond</b>							
II	3. NAME OF DECEASED (Type or print) <b>Quentin</b>	First Lewis Middle Lewis Last	4. DATE OF DEATH <b>MARCH 4 1960</b>						
III	5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 28, 1951</b>	9. AGE (In years from birthday) <b>8 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Year Hours Min. <b>1960</b>	
IV	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
V	13. FATHER'S NAME <b>JAMES Lewis</b>	14. MOTHER'S MAIDEN NAME <b>Elizabeth Mills</b>							
VI	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>Elizabeth Mills, EASTON, MD.</b>						
7	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>916.0</b>	DUE TO <b>Asphyxiation in Dunninghouse</b>	INTERVAL BETWEEN ONSET AND DEATH <b>—</b>						
8	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>—</b>	(b) <b>—</b>	(c) <b>—</b>						
9	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
10	20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Home burned - tripped in house</b>			20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>3-4 1960</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	20f. (City or town) <b>EASTON, MD.</b>	(County) <b>MD.</b>	(State) <b>MD.</b>
11	21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
12	ACTUAL SIGNATURE <b>Lewis Shultz</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <b>3-8-60</b>				
13	EXAMINER'S NAME (Type) <b>W E L T Y</b>	22b. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22c. DATE THEREOF <b>3/9/60</b>	22d. NAME OF CEMETERY OR CREMATORIAL <b>Richards Cem.</b>	22d. LOCATION (City, town, or county) <b>EASTON</b>	(State) <b>MD.</b>			
14	23. FUNERAL DIRECTOR'S SIGNATURE <b>James S. Darkeill, EASTON, MD.</b>	ADDRESS	24a. REC'D. BY REGISTRAR <b>MAR 10 1960</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trahan</b>					
15	V8. A15ME 5M 2/57		DATE						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3844 CERTIFICATE OF DEATH

64996

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Talbot</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN 1b <b>3 mos</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>40 Easton</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>115 Idlewild Avenue</b>				d. STREET ADDRESS <b>115 Idlewild Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Ernest Hugh</b>		First	Middle	Last	4. DATE OF DEATH <b>March</b>	Month	Day	Year <b>30 1960</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 15<sup>th</sup> 1875</b>	9. AGE (In years ( <sup>1st</sup> birthday) <b>84 yrs.</b> )	IF UNDER 1 YEAR <b>Months</b>	IF UNDER 24 HRS. <b>Days</b>	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Church</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>ukn</b>				14. MOTHER'S MAIDEN NAME <b>ukn</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>ukn</b>		17. INFORMANT <b>Mr. J. H. MacEwen, Easton, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		<i>Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		<i>Atherosclerotic Coronary Disease</i> = 71y		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore, Maryland</b>		(County) <b>Maryland</b> (State)
21. I certify that I attended the deceased from _____								
alive on _____								
ACTUAL SIGNATURE <i>P. Evans Cox</i>						DATE SIGNED		
PHYSICIAN'S NAME (Type) <b>P. Evans Cox, MD</b>				Easton, Maryland				
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/4/60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Frampton Carroll</i>		ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 19 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arnold S. Mann</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 to be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

416

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3845

## CERTIFICATE OF DEATH

Reg. Dist. No.

103791

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>22 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <u>Genevieve</u>	Middle <u>Louise</u>	Last <u>Marshall</u>
4. DATE OF DEATH	Month <u>3</u>	Day <u>28</u>	Year <u>1960</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <u>MAY 25, 1921</u>
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>38 yrs.</u>	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>ST. MICHAELS, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH S. JACKSON</u>		14. MOTHER'S MAIDEN NAME <u>CLARA O. NEWNAM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u>		16. SOCIAL SECURITY NO. <u>214-34-5379</u>	
17. INFORMANT <u>LUTHER M. MARSHALL, WITTMAN, MD</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> DUE TO <u>199.2</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cachexia severe - generalized</u> DUE TO <u>—</u> (c) <u>adenocarcinomatosis - generalized - metastatic</u> DUE TO <u>—</u> 10 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>generalized - metastatic</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <u>at work</u> Not while <u>at work</u> <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>St. Michaels</u> (County) <u>St. Michaels</u> (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>60</u> , to <u>3-28-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-28-60</u> , 19 <u>60</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Guy M. Reeser Jr. MD</u>		ADDRESS (Street, city or town, state) <u>St. Michaels, MD</u> DATE SIGNED <u>3-28-60</u>	
PHYSICIAN'S NAME (Type) <u>Guy M. Reeser Jr. MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-31-60</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Oliver Cemetery</u>		22d. LOCATION (City, town, or county) <u>St. Michaels, MD</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ElGamblin Harrison, St. Michaels, MD</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

PHOTOGRAPH BY THE STATE BAR OF  
CALIFORNIA STAFF

PAGE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3846

## CERTIFICATE OF DEATH

64997

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Talbot

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

EASTON

c. LENGTH OF STAY IN 1b

1 day

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

EASTON MEMORIAL Hosp.

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

March

27

1960

## 5. SEX

FEMALE

## 6. COLOR OR RACE

WHITE

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

FEB. 18, 1884

## 9. AGE (In years last birthday)

76 yrs.

## IF UNDER 1 YEAR

Months Days Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWORK

## 10b. KIND OF BUSINESS OR INDUSTRY

HOUSEWIFE

## 11. BIRTHPLACE (State or foreign country)

MARYLAND

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

WM FREDERICK BRIGGEMAN

## 14. MOTHER'S MAIDEN NAME

Julia Letmate

15. WAS DECEASED EVER IN U. S. ARMED FORCES?   
(Yes, no, or unknown)

## 16. SOCIAL SECURITY NO.

None

## INFORMANT

V.N.K.

Mrs. Julia Evans, EASTON, MD

Address 510 AUGUST ST.

NO

331X

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Cervico-vascular accident

(INTERVAL BETWEEN ONSET AND DEATH)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)

DUE TO

Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c)

DUE TO

Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.

(INTERVAL BETWEEN ONSET AND DEATH)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

Bi-lateral lobular pneumonia

19. WAS AUTOPSY PERFORMED?  
YES  NO YES  NO

334X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3847 CERTIFICATE OF DEATH

Reg. Dist. No.

103792

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after death. Page 4  
be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON.</i>		c. LENGTH OF STAY IN 1b <i>5 days.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Rural</i>		d. STREET ADDRESS <i>Oxford</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>James</i>		First	Middle	Last	4. DATE OF DEATH <i>March 11</i>	Month	Day	Year <i>1960</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 16, 1875</i>		9. AGE (In years last birthday) <i>84</i>	IF UNDER 1 YEAR Months <i>84</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>PENNA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Charles McWilliams</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>				Address <i>Oxford, Md.</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>N/A</i>		INFORMANT <i>Mr. Ralph Petallack</i>		17. INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Left Middle Cerebral Artery Thrombosis</i> DUE TO <i>332X</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Arteriosclerosis Generalized</i> DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>March 6, 1960</i> to <i>March 10, 1960</i> , that I last saw the deceased alive on <i>March 10, 1960</i> , and that death occurred at <i>4:35 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>EASTON</i> DATE SIGNED <i>3/13/60</i>								
ACTUAL SIGNATURE <i>A. Kech Jr.</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>SHEPARD</i>		<i>KRECH, JR.</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar. 14, 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Spring Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>EASTON, Maryland</i> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice E. Newman &amp; Son</i>		ADDRESS <i>EASTON, Md.</i>		24a. REC'D BY REGISTRAR <i>C. L. Thompson</i>		24b. REGISTRAR'S SIGNATURE <i>C. L. Thompson</i>		
VS AIS (4) 1SM 9/58		DATE <i>MAR 16 '60</i>						

STATE OF TEXAS  
DEPARTMENT OF PUBLIC SAFETY

DPS

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

03793

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**3848 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>108 Hammond</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>	
3. NAME OF DECEASED (Type or print) <b>Doretha</b>		4. DATE OF DEATH <b>March 4 1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Oct 27, 1958</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARles Copper</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Mills</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Elizabeth Mills, EASTON</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Asphyxiation in burning house</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. <b>916.0</b>		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
DUE TO (b) <b>—</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Home burned - trapped = house</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>3-4 1960</b> p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) <b>Easton Tal</b>	
(County) <b>md</b>		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Lewis W. Weller</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>WELLER</b>		DATE SIGNED <b>3-8-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/9/60</b>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Richards Cem</b>		22d. LOCATION (City, town, or county) <b>Easton</b>	
(State) <b>md.</b>			
24a. REC'D BY REGISTRAR <b>Arthur S. Khan</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Khan</b>	
DATE MAR 10 '60			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03794

**Reg. Dist. No.**

FOR STATE  
HEALTH DEPT.

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**NO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
talbot		a. STATE md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb		b. COUNTY talbot
EASTON	life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
108 Hammond	108 Hammond		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	Y	e	onne
4. DATE OF DEATH	Month	Day	Year
May 11/58	March	4	1960
5. SEX	6. COLOR OF RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
m	Col	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 17, 1958
9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
yrs.	—	—	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Robert Jenkins	Diane Mills		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
(If yes, give war or dates of service)			Diane mills, Easton, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation in burning home			
DUE TO			
Conditions, if any, which gave rise to immediate cause (b)			
(a), stating the underlying cause last. DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Home burned - trapped in room.		
20c. TIME OF INJURY Month, Day, Year Hour a.m. m.p.m. 3-4 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) Home Easton Talbot Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3-8-60
EXAMINER'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 319/60	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Richards Cem.	22d. LOCATION (City, town, or county) (State) Easton Md.
23. FUNERAL DIRECTOR'S SIGNATURE James DeMille, Easton, Md.	24a. REC'D BY REGISTRAR MAR 10 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

VS. A15ME  
5M 2/57

STATE OF CALIFORNIA—SACRAMENTO  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3850

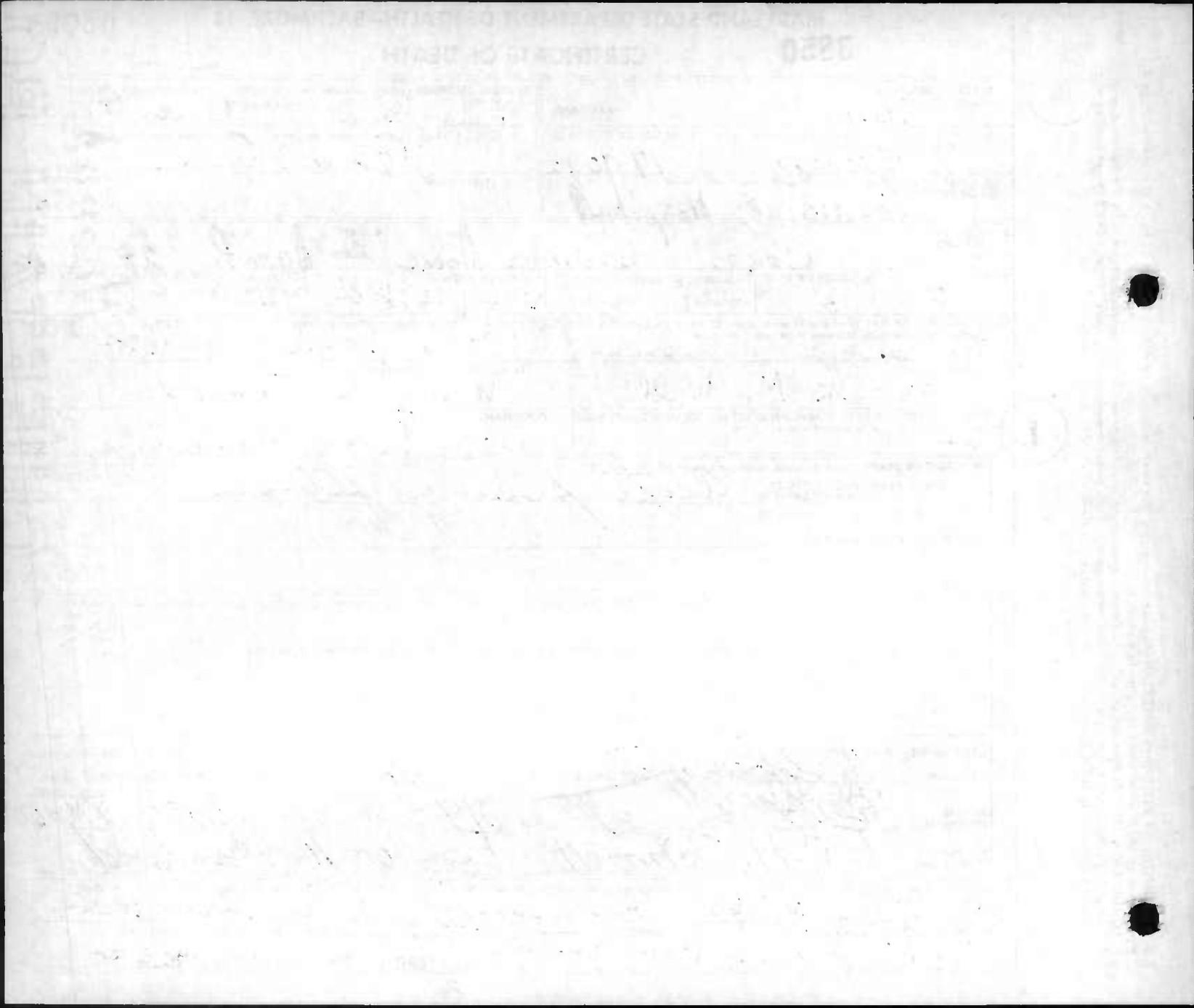
## CERTIFICATE OF DEATH

Reg. Dist. No.

03795

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		2		3	
I		II		III	
<p><b>1. PLACE OF DEATH</b>        a. COUNTY <u>Talbot</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u></p> <p>c. LENGTH OF STAY IN 1b <u>17 days</u></p> <p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u></p>					
<p><b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission)        a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne</u></p> <p>d. STREET ADDRESS <u>17X-2</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					
<p><b>3. NAME OF DECEASED</b>        (Type or print) <u>Cora Navinia Moore</u></p>		<p><b>4. DATE OF DEATH</b>        Month <u>March</u> Day <u>28</u> Year <u>1960</u></p>			
<p><b>5. SEX</b> <u>F</u></p>		<p><b>6. COLOR OR RACE</b> <u>W</u></p>		<p><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>        WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p><b>8. DATE OF BIRTH</b> <u>JULY 12, 1885</u></p>		<p><b>9. AGE</b> (In years last birthday) <u>74 yrs.</u></p>		<p><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u></p>	
<p><b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u></p>		<p><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>home</u></p>	
<p><b>13. FATHER'S NAME</b> <u>Frank M. Willis</u></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <u>Mary L. Turner</u></p>			
<p><b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>—</u></p>		<p><b>16. SOCIAL SECURITY NO.</b></p>		<p><b>INFORMANT</b> <u>Harry Moore, Queen Anne, Md.</u></p>	
<p><b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:        IMMEDIATE CAUSE (a) <u>525X</u> DUE TO <u>Acute pulmonary fibrosis</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____        (c) _____</p> <p>DUE TO <u>acute pulmonary fibrosis</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>					
<p><b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>					
<p><b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b></p>		<p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p><b>20c. TIME OF INJURY</b> Month <u>Mar.</u> Day <u>19</u>        Hour a. m. <u>19</u> p. m. <u>—</u></p>		<p><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>540A</u></p> <p><b>20f. (City or town)</b> <u>Easton</u> (County) <u>Queen Anne</u> (State) <u>Md.</u></p>	
<p><b>21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <u>540A</u>, from the causes and on the date stated above.</b></p>					
<p><b>ACTUAL SIGNATURE</b> <u>E-G-H. Schmidt</u></p>		<p><b>ADDRESS</b> (Street, city or town, state) <u>219 S. Washington St., Easton, Maryland</u></p>		<p><b>DATE SIGNED</b> <u>28 Mar 60</u></p>	
<p><b>PHYSICIAN'S NAME (Type)</b> <u>E-G-H. Schmidt</u></p>					
<p><b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial Mar 31, 1960</u></p>		<p><b>22b. DATE THEREOF</b> <u>Mar 31, 1960</u></p>		<p><b>22c. NAME OF CEMETERY OR CREMATORIAL</b> <u>Greenboro</u></p>	
<p><b>22d. LOCATION (City, town, or county)</b> <u>Greenboro</u></p>					
<p><b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Selma Mooreton Denton</u></p>		<p><b>ADDRESS</b> <u>—</u></p>		<p><b>24a. REC'D BY REGISTRAR</b> <u>APR 1 '60</u></p>	
				<p><b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Haas</u></p>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4999

3868

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Talbot</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural-Cordova</b>		c. LENGTH OF STAY IN 1b <b>1 yr</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cordova</b>		d. STREET ADDRESS <b>Rural</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>at home</b>				d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Henry</b>	Middle <b>Morgan</b>	Last <b>Noe</b>	4. DATE OF DEATH Month <b>March</b>	Month <b>30</b>	Day <b>19</b>	Year <b>60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 28, 1886</b>	9. AGE (In years lost birthday) <b>73 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ret.</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>ukn</b>			14. MOTHER'S MAIDEN NAME <b>ukn</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>ukn</b>		16. SOCIAL SECURITY NO. <b>ukn</b>		17. INFORMANT <b>Mrs. Milton Rowen, Cordova, RD, Maryland</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerosis / heart dis</b> DUE TO <b>3 yrs</b> INTERVAL BETWEEN ONSET AND DEATH 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Easton</b>		20f. (City or town) (County) <b>Easton</b> (Md.)		(State) <b>MD</b>
21. I certify that I attended the deceased from <b>1957</b> , to <b>3/30/60</b> , that I last saw the deceased alive on <b>3/28/60</b> , and that death occurred at <b>5a</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>M. Cox</b> M.D. <b>Easton</b> (Md.) <b>3/30/60</b> ADDRESS (Street, city or town, state) DATE SIGNED								
22a. BURIAL, CREMATION, REMOVAL, ETC. <b>Burial</b>		22b. DATE THEREOF <b>April 1, '60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Ferncliff Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hartsdale, New York</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>D. Hampton Gandy</b>		ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 19 60</b>		24b. REGISTRAR'S SIGNATURE <b>Oakes S. Krause</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13797

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

3869

Item 7, Film G259, 3/18/60 1b

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 could be forwarded to the Chief Medical Examiner's Office along with form PNA3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

1		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
		Item 7, Film G259, 3/18/60 1b											
 		1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)								
		a. COUNTY <b>Talbot</b> MARYLAND			a. STATE <b>Md</b> b. COUNTY <b>Talbot</b>								
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Queen Anne Rural</b>			c. LENGTH OF STAY IN 1b d. STREET ADDRESS								
					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Queen Anne Rural</b>								
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
		3. NAME OF DECEASED (Type or print) <b>Charles</b>			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
							<b>PINKNEY</b>	3	9	1960			
		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>Col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>1886</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
								<b>1886</b>	<b>73</b> yrs.				
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dry Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Canning</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
		13. FATHER'S NAME <b>CHARLES PINKNEY</b>			14. MOTHER'S MAIDEN NAME <b>Mary Unknown</b>								
		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>123-45-6789</b>			17. INFORMANT <b>Keggie Blakney Queen Anne, Md.</b>			Address		
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			Exposure to weather						INTERVAL BETWEEN ONSET AND DEATH		
		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>932,8</b> DUE TO			(b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(c)					
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell into snowbank while under ? influence</b>									
		20c. TIME OF INJURY Hour <b>7</b> o. m. p. m. <b>3</b> 9 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Tavern</b>		20f. (City or town) <b>Queen Anne</b>		(County) <b>Talbot</b>		(State) <b>Md</b>	
		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
		ACTUAL SIGNATURE <b>Lewis White</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3-9-60</b>			
		EXAMINER'S NAME (Type) <b>WHITE</b>											
		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 12, 1960</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Sandtown</b>		22d. LOCATION (City, town, or county) <b>Hillside</b>		(State) <b>Md.</b>			
		23. FUNERAL DIRECTOR'S SIGNATURE <b>J. V. Mooreson Dated 3-9-60</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>DATE MAR 14 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Orville S. Kline</b>					



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3851 CERTIFICATE OF DEATH

05602

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>13 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mr. Albert Sidney Price</i>		First <i>Albert</i>	Middle <i>Sidney</i>
4. DATE OF DEATH <i>March 29 1960</i>		Last <i>Price</i>	Month Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 4, 1875</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>merchant-ret.</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>grocery store</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Thomas E. Price</i>		14. MOTHER'S MAIDEN NAME <i>Sahah Katherine Todd</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>ukn</i>	INFORMANT Address <i>Thomas E. Price, Dover Rd., Easton, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Thrombosis</i> DUE TO (c) <i>Generalized Arterosclerosis</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pneumonia</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>3/17 1960 to 3/29 1960</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>Easton, Md.</i>
21. I certify that I attended the deceased from <i>3/17 1960</i> to <i>3/29 1960</i> , that I last saw the deceased alive on <i>3/29 1960</i> , and that death occurred at <i>6:55A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ludwig Eglseider</i>		ADDRESS (Street, city or town, state) M.D. <i>Easton, Md.</i> DATE SIGNED <i>3/30/60</i>	
PHYSICIAN'S NAME (Type) <i>Ludwig Eglseider</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	
22b. DATE THEREOF <i>3/31/60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Spring Hill Cemetery</i>	
22d. LOCATION (City, town, or county) <i>EASTON MD.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Hampton Carroll, Easton, Md.</i>		ADDRESS	
		24a. REC'D BY REGISTRAR <i>APR 19 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

33x

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3865

## CERTIFICATE OF DEATH

Reg. Dist. No.

03860

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ST. MICHAELS</b>		c. LENGTH OF STAY IN 1b RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RIO VISTA NURSING HOME</b>		e. STREET ADDRESS <b>X BOZMAN</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>GERTRUD</b>	Middle <b>SCOTT</b>	4. DATE OF DEATH Month <b>MARCH</b> Day <b>7</b> Year <b>1960</b>
5. SEX <b>FEM.</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 20 - 1870</b>
9. AGE (In years last birthday) <b>89</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>NICHOLAS SCHMIDT</b>	14. MOTHER'S MAIDEN NAME <b>MARY MEILLER</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT <b>MRS. ROBERT EIRICH - Bozman MD.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>adenocarcinoma ovary</b> DUE TO <b>175.0</b> INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>widespread metastases</b> , — (c) <b>cardiac failure</b> 2 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cachexia - severe - generalized.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2-17 - 1960</b> to <b>3-7 - 1960</b> that I last saw the deceased alive on <b>3-7 - 1960</b> , and that death occurred at <b>4:40 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry M. Reeser Jr.</i>	M.D.		ADDRESS (Street, city or town, state) <b>St. Michaels MD</b> DATE SIGNED <b>3-7-60</b>
PHYSICIAN'S NAME (Type) <b>Henry M. Reeser Jr. MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1 MARCH 10</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>CHURCH HILL</b>	22d. LOCATION (City, town, or county) <b>CHURCH HILL</b> (State) <b>MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE. <b>EDGAR L. LANE</b>	ADDRESS <b>CHURCH HILL</b>	24a. REC'D BY REGISTRAR DATE <b>MAR 15 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Turner</b>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MANUFACTURED STATE DEPARTMENT OF HEALTH—REGISTRATION 18  
CERTIFICATE OF DEATH 3235

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3852 CERTIFICATE OF DEATH

03801

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		b. COUNTY <i>TALBOT</i>	
c. LENGTH OF STAY IN 1b <i>4 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 EASTON</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First <i>Susan</i>	Middle <i>Martha</i>	Last <i>Seymour</i>	4. DATE OF DEATH <i>March 2 1960</i>	Month	Day	Year
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>FEB. 20, 1876</i>	9. AGE (In years last birthday) <i>84 yrs.</i>	IF UNDER 1 YEAR Months	Days	Hours

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>A. S.</i>
---	---	--	--

13. FATHER'S NAME <i>JOHN R. WARNER</i>	14. MOTHER'S MAIDEN NAME <i>ELIZA JONES</i>	Address <i>MRS. DORIS WRIGHT EASTON</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	16. SOCIAL SECURITY NO. <i>—</i>	INFORMANT <i>—</i>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>	Acute pulmonary edema	8 hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>—</i>	Paroxysmal atrial tachycardia	8 hrs.
(c) DUE TO <i>—</i>	arteriosclerotic heart disease	14 yrs.

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

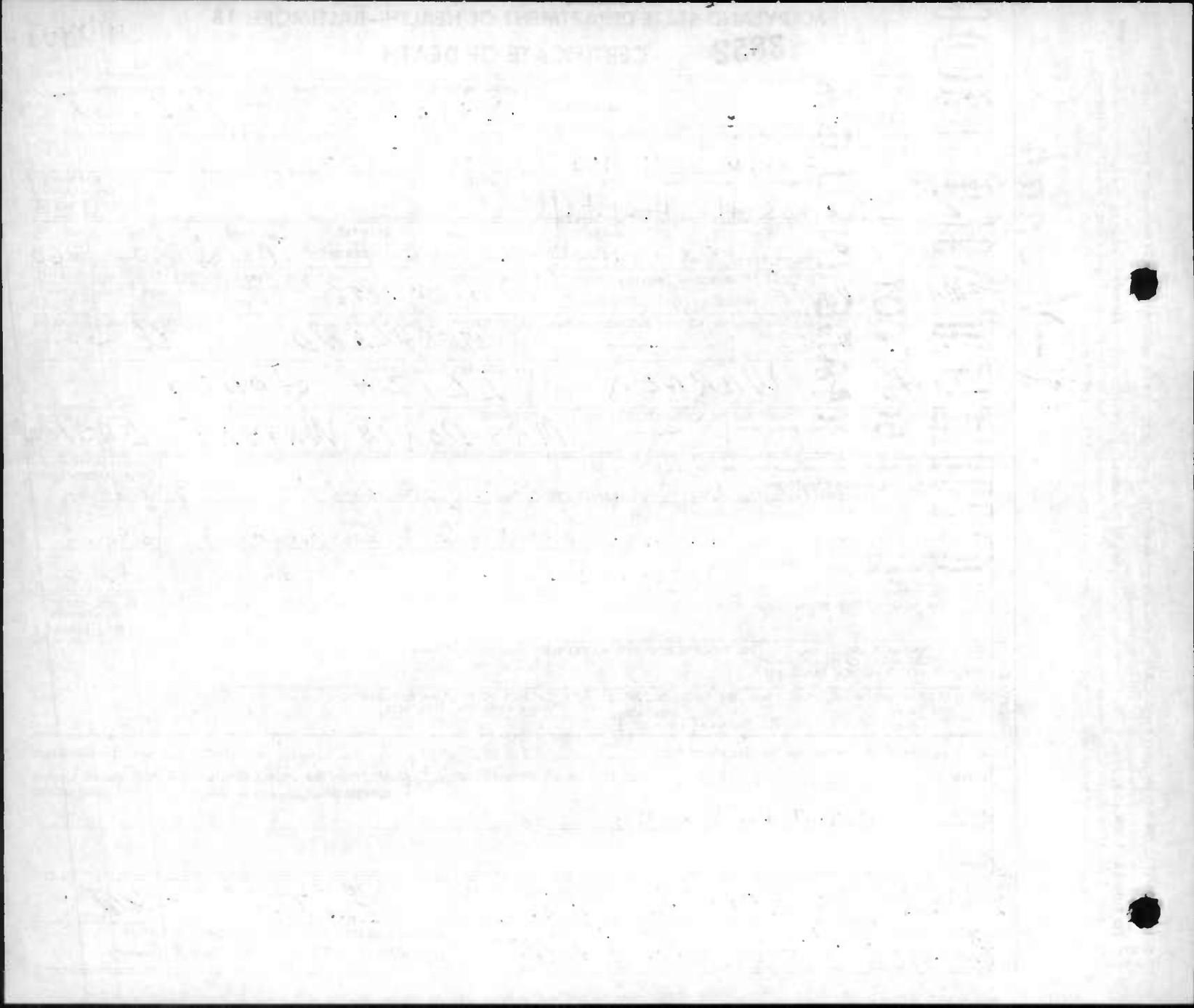
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above.
--

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE <i>Robert W. Trevor</i>	M.D.
PHYSICIAN'S NAME (Type)	

22a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	22b. DATE THEREOF <i>Mar. 5, 1960</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Spring Hill</i>	22d. LOCATION (City, town, or county) <i>Easton</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James E. Trevor Esq. Easton</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 9 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3853

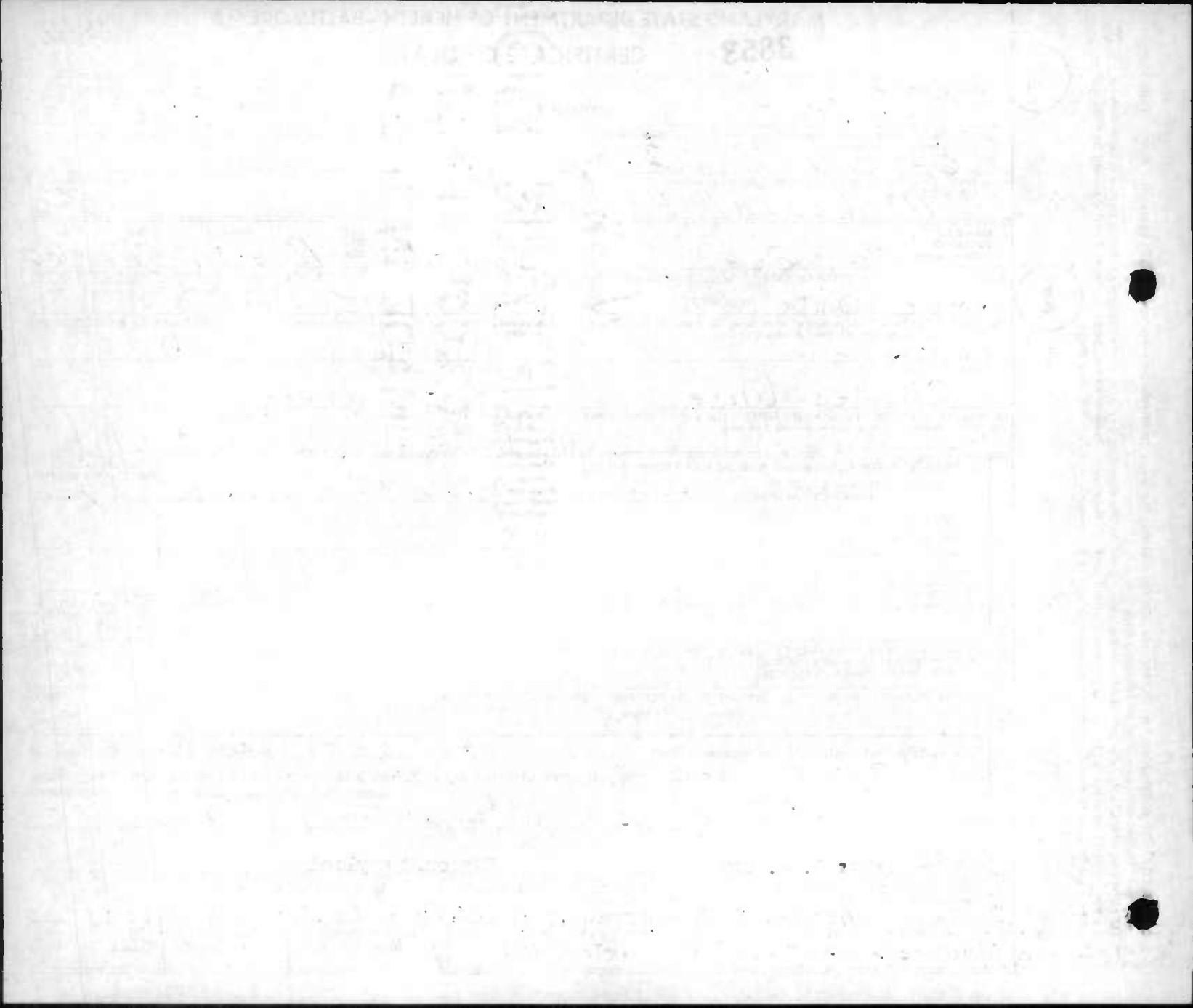
## CERTIFICATE OF DEATH

Reg. Dist. No. 03802

1		PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		
080		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		b. COUNTY <i>Talbot</i>		
I		c. LENGTH OF STAY IN lb <i>25 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X rural Easton</i>		
0		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp. tal</i>		d. STREET ADDRESS		
1		3. NAME OF DECEASED (Type or print)	First <i>Mrs. Eva</i>	Middle	4. DATE OF DEATH <i>Slaughter March 7 1960</i>	
1		5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 28, 1895</i>	
1		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
0		13. FATHER'S NAME <i>Charles Wise</i>	14. MOTHER'S MAIDEN NAME <i>Ruth Green</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		
1		16. SOCIAL SECURITY NO.	INFORMANT <i>Mr. Robert Slaughter</i>	Address <i>Easton, Md.</i>		
1		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>arteriosclerotic Heart Disease 2 yrs</i>				INTERVAL BETWEEN ONSET AND DEATH
1		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
1		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
1		21. I certify that I attended the deceased from _____, 19____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Easton, Md.</i>
1		ACTUAL SIGNATURE <i>P. E. Cox</i>	M.D.		DATE SIGNED <i>Mar. 1960</i>	
1		PHYSICIAN'S NAME (Type) <i>Doctor P. E. Cox</i>	Easton, Maryland			
1		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Mar. 10, 1960</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Hill Cemetery</i>	22d. LOCATION (City, town, or county) <i>Easton Maryland</i>	
1		23. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice L. Newman &amp; Son</i>	ADDRESS <i>Easton, Md.</i>	24a. REC'D BY REGISTRAR <i>MAR 19 1960</i>	24b. REGISTRAR'S SIGNATURE <i>Ernest S. Kraus</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after death. Page 4  
 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

15664

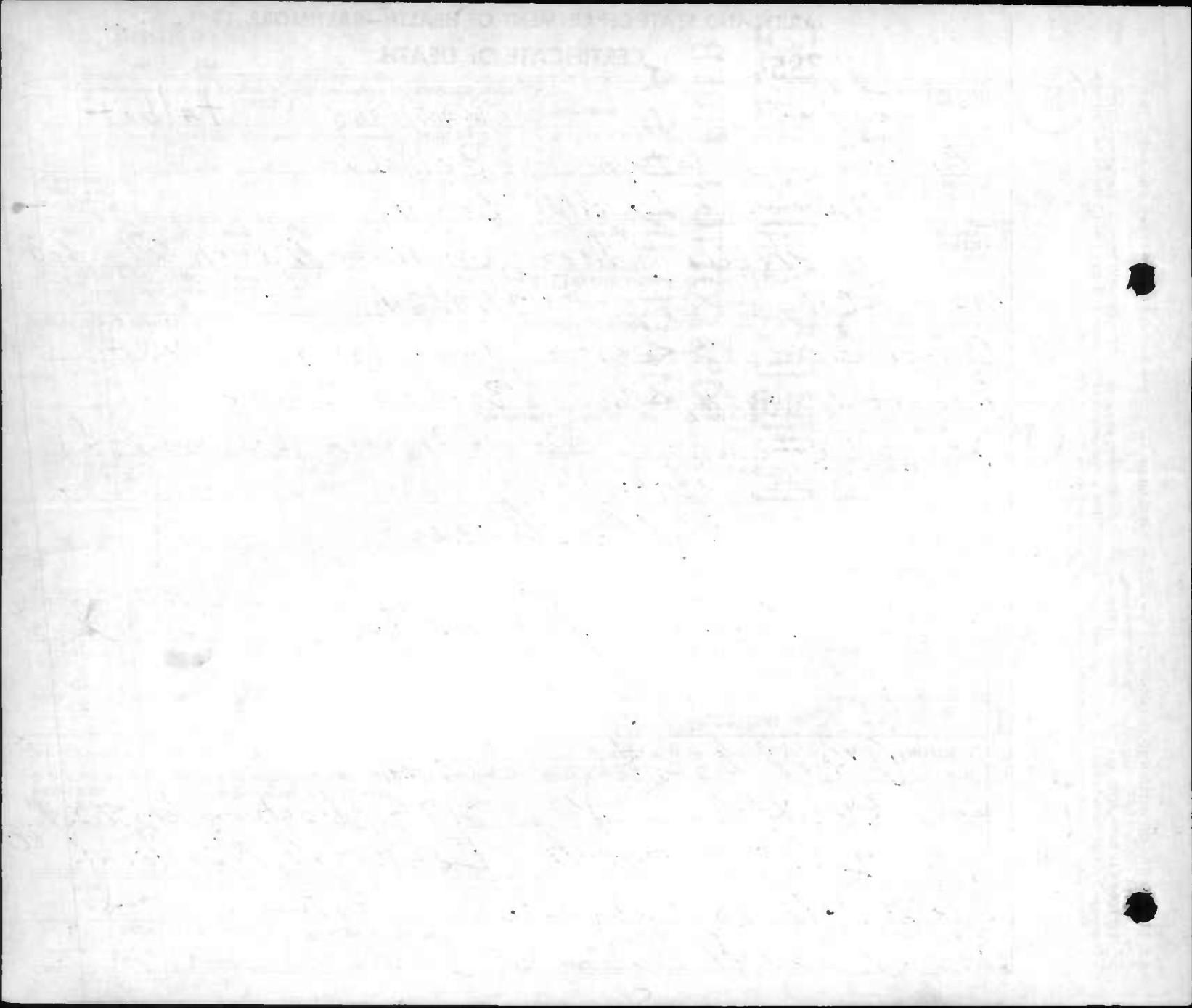
## CERTIFICATE OF DEATH

Reg. Dist. No.

3854

1. PLACE OF DEATH a. COUNTY <i>Salisbury</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>6 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William Henry Smith</i>		First <i>William</i>	Middle <i>Henry</i>
4. DATE OF DEATH <i>March 27 1960</i>	Month <i>March</i>	Day <i>27</i>	Year <i>1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/17/24</i>
9. AGE (In years last birthday) <i>35 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Construction</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>Robert J. Smith SR.</i>		
14. MOTHER'S MAIDEN NAME <i>Bertha Cooper</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes WWII</i>		
16. SOCIAL SECURITY NO. <i>123-45-6789</i>		INFORMANT <i>James Thomas Bellone, Jr.</i>	Address <i>Bellone, Jr.,</i>
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.3</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>Nephroelosis</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>None</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Heart failure, pericarditis</i>		18. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 6:50 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>219 S Washington St, Baltimore, Maryland</i>	
ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>		DATE SIGNED <i>28 Mar 60</i>	
PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	
22b. DATE THEREOF <i>4/2/68</i>		22c. NAME OF CEMETERY, OR CREMATORIUM <i>Rhonda Cem.</i>	
22d. LOCATION (City, town, or county) <i>Easton</i>		(State) <i>md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Daniel</i>		24a. REC'D BY REGISTRAR DATE APR 7 '60	
ADDRESS <i>Easton, MD</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>	

Hospital or attending physician  
to be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3855

## CERTIFICATE OF DEATH

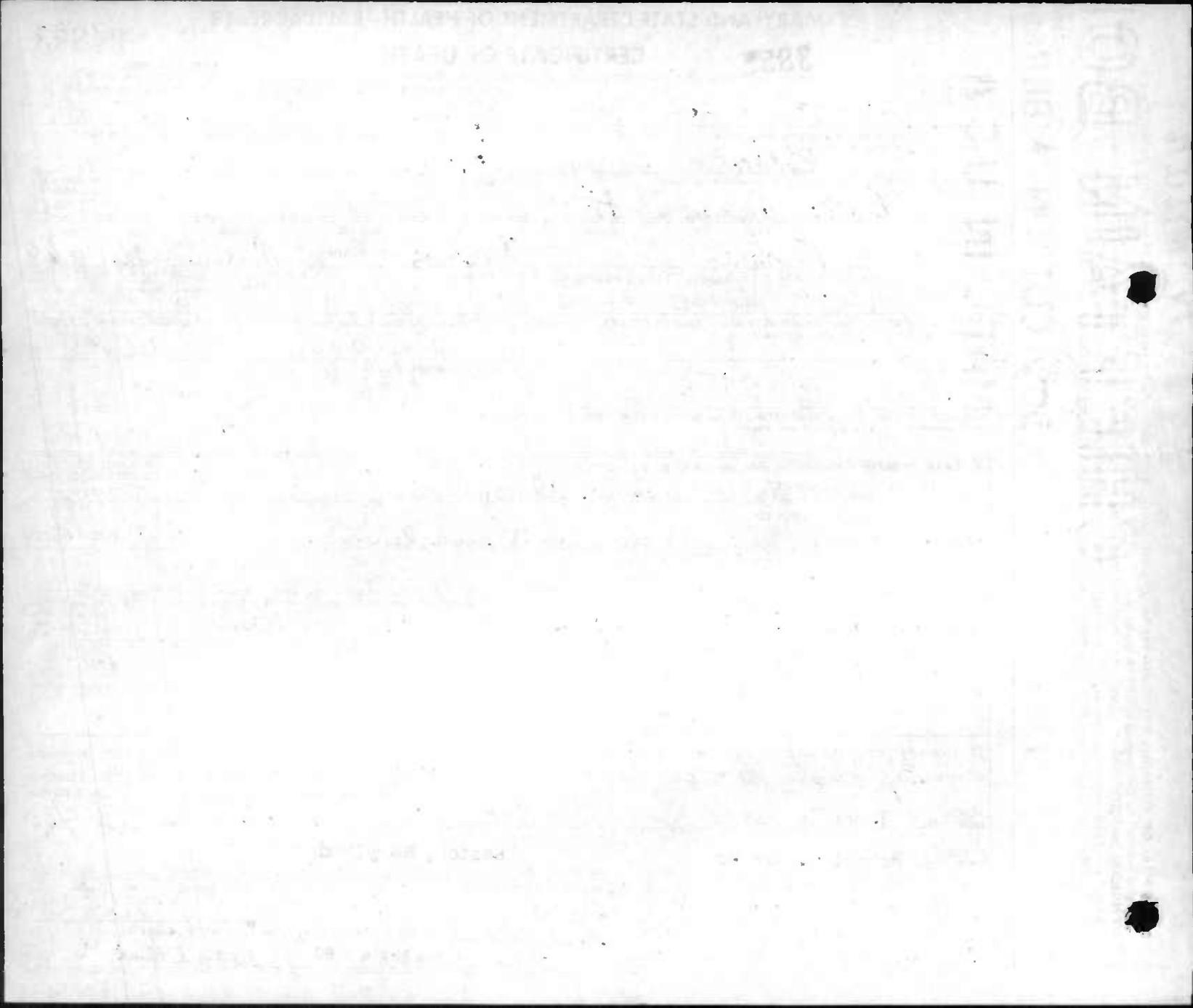
Reg. Dist. No.

03803

1 38 M 080 I O 1 1		2. PLACE OF DEATH a. COUNTY <b>TALBOT</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b> c. LENGTH OF STAY IN 1b <b>3 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton Memorial Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Del</b> b. COUNTY <b>Kent</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wilmington</b> d. STREET ADDRESS <b>-</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emma</b>		First	Middle	Last	4. DATE OF DEATH <b>Stevens</b>	Month	Day	Year	
5. SEX <b>Fem.</b>		6. COLOR OR RACE <b>cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 7, 1890</b>	9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Let dates</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Henry C Stevens</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Warner</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT <b>Harvey Stevens</b>		Address <b>Pitman New Jersey</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Cerebral thrombosis (c) DUE TO Cerebral arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH <b>3days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Previous cerebral thrombosis. Diabetes mellitus.</b>						Unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Previous cerebral thrombosis. Diabetes mellitus.</b>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/23</b> , 19 <b>60</b> , to <b>3/26</b> , 19 <b>60</b> , and that I last saw the deceased alive on <b>3/26</b> , 19 <b>60</b> , and that death occurred at <b>9:36 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>R. W. Trever</b> PHYSICIAN'S NAME (Type) <b>Robert W. Trever</b>								ADDRESS (Street, city or town, state) <b>Easton, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>30 March 60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Odd Fellows</b>		22d. LOCATION (City, town, or county) <b>Camden</b>		(State) <b>Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J Harvey Williamson</b>		ADDRESS <b>Federalburg Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Traus</b>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4  
 TO be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



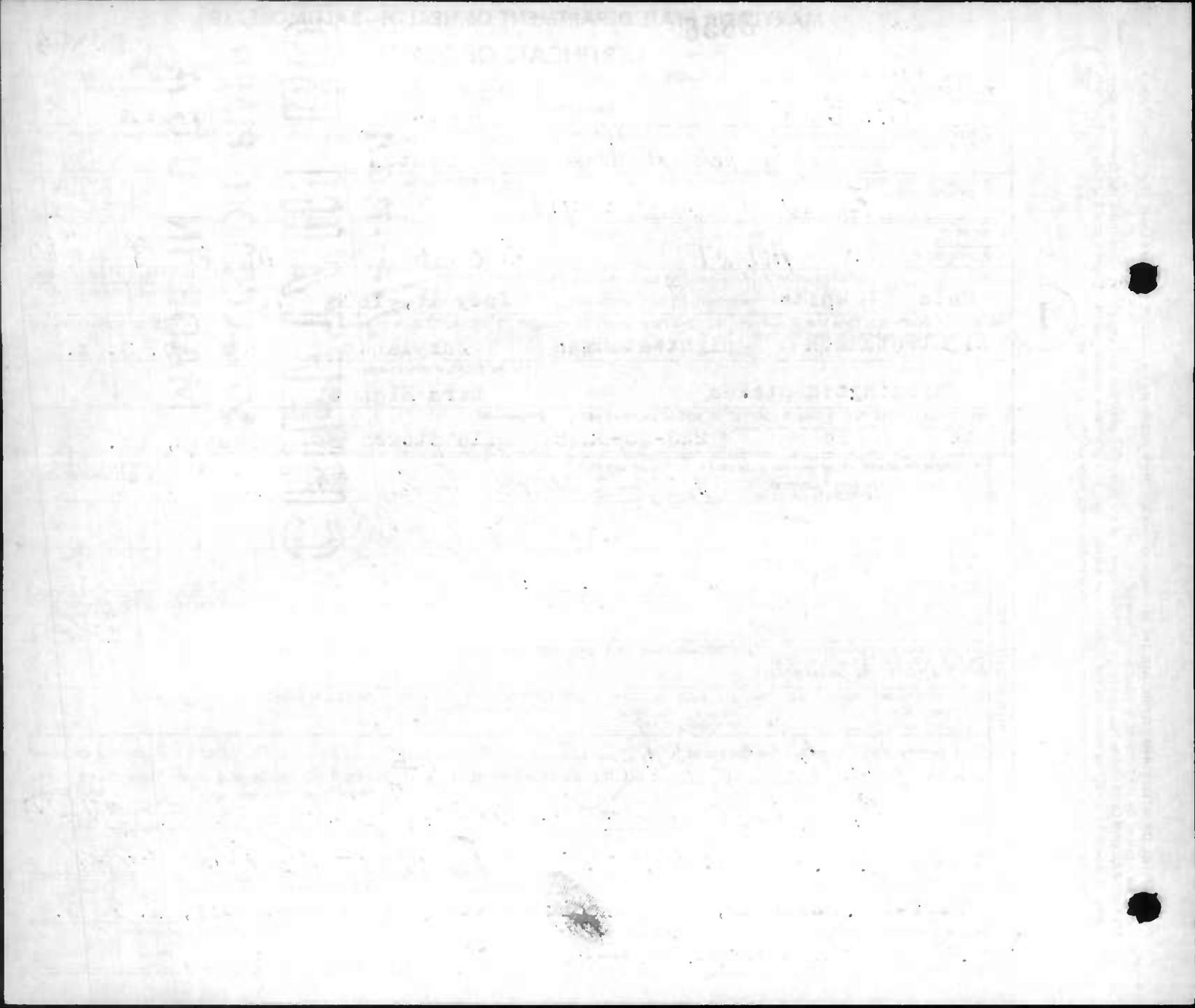
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3856 CERTIFICATE OF DEATH

Reg. Dist. No.

03804

1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.		M	
1		2	
3		4	
5		6	
7		8	
9		10	
11		12	
13		14	
15		16	
17		18	
19		20	
21		22	
23		24	
25		26	
27		28	
29		30	
31		32	
33		34	
35		36	
37		38	
39		40	
41		42	
43		44	
45		46	
47		48	
49		50	
51		52	
53		54	
55		56	
57		58	
59		60	
61		62	
63		64	
65		66	
67		68	
69		70	
71		72	
73		74	
75		76	
77		78	
79		80	
81		82	
83		84	
85		86	
87		88	
89		90	
91		92	
93		94	
95		96	
97		98	
99		100	
101		102	
103		104	
105		106	
107		108	
109		110	
111		112	
113		114	
115		116	
117		118	
119		120	
121		122	
123		124	
125		126	
127		128	
129		130	
131		132	
133		134	
135		136	
137		138	
139		140	
141		142	
143		144	
145		146	
147		148	
149		150	
151		152	
153		154	
155		156	
157		158	
159		160	
161		162	
163		164	
165		166	
167		168	
169		170	
171		172	
173		174	
175		176	
177		178	
179		180	
181		182	
183		184	
185		186	
187		188	
189		190	
191		192	
193		194	
195		196	
197		198	
199		200	
201		202	
203		204	
205		206	
207		208	
209		210	
211		212	
213		214	
215		216	
217		218	
219		220	
221		222	
223		224	
225		226	
227		228	
229		230	
231		232	
233		234	
235		236	
237		238	
239		240	
241		242	
243		244	
245		246	
247		248	
249		250	
251		252	
253		254	
255		256	
257		258	
259		260	
261		262	
263		264	
265		266	
267		268	
269		270	
271		272	
273		274	
275		276	
277		278	
279		280	
281		282	
283		284	
285		286	
287		288	
289		290	
291		292	
293		294	
295		296	
297		298	
299		300	
301		302	
303		304	
305		306	
307		308	
309		310	
311		312	
313		314	
315		316	
317		318	
319		320	
321		322	
323		324	
325		326	
327		328	
329		330	
331		332	
333		334	
335		336	
337		338	
339		340	
341		342	
343		344	
345		346	
347		348	
349		350	
351		352	
353		354	
355		356	
357		358	
359		360	
361		362	
363		364	
365		366	
367		368	
369		370	
371		372	
373		374	
375		376	
377		378	
379		380	
381		382	
383		384	
385		386	
387		388	
389		390	
391		392	
393		394	
395		396	
397		398	
399		400	
401		402	
403		404	
405		406	
407		408	
409		410	
411		412	
413		414	
415		416	
417		418	
419		420	
421		422	
423		424	
425		426	
427		428	
429		430	
431		432	
433		434	
435		436	
437		438	
439		440	
441		442	
443		444	
445		446	
447		448	
449		450	
451		452	
453		454	
455		456	
457		458	
459		460	
461		462	
463		464	
465		466	
467		468	
469		470	
471		472	
473		474	
475		476	
477		478	
479		480	
481		482	
483		484	
485		486	
487		488	
489		490	
491		492	
493		494	
495		496	
497		498	
499		500	
501		502	
503		504	
505		506	
507		508	
509		510	
511		512	
513		514	
515		516	
517		518	
519		520	
521		522	
523		524	
525		526	
527		528	
529		530	
531		532	
533		534	
535		536	
537		538	
539		540	
541		542	
543		544	
545		546	
547		548	
549		550	
551		552	
553		554	
555		556	
557		558	
559		560	
561		562	
563		564	
565		566	
567		568	
569		570	
571		572	
573		574	
575		576	
577		578	
579		580	
581		582	
583		584	
585		586	
587		588	
589		590	
591		592	
593		594	
595		596	
597		598	
599		600	
601		602	
603		604	
605		606	
607		608	
609		610	
611		612	
613		614	
615		616	
617		618	
619		620	
621		622	
623		624	
625		626	
627		628	
629		630	
631		632	
633		634	
635		636	
637		638	
639		640	
641		642	
643		644	
645		646	
647		648	
649		650	
651		652	
653		654	
655		656	
657		658	
659		660	
661		662	
663		664	
665		666	
667		668	
669		670	
671		672	
673		674	
675		676	
677		678	
679		680	
681		682	
683		684	
685		686	
687		688	
689		690	
691		692	
693		694	
695		696	
697		698	
699		700	
701		702	
703		704	
705		706	
707		708	
709		710	
711		712	
713		714	
715		716	
717		718	
719		720	
721		722	
723		724	
725		726	
727		728	
729		730	
731		732	
733		734	
735		736	
737		738	
739		740	
741		742	
743		744	
745		746	
747		748	
749		750	
751		752	
753		754	
755		756	
757		758	
759		760	
761		762	
763		764	
765		766	
767		768	
769		770	
771		772	
773		774	
775		776	
777		778	
779		780	
781		782	
783		784	
785		786	
787		788	
789		790	
791		792	
793		794	
795		796	
797		798	
799		800	
801		802	
803		804	
805		806	
807		808	
809		810	
811		812	
813		814	
815		816	
817		818	
819		820	
821		822	
823		824	
825		826	
827		828	
829		830	
831		832	
833		834	
835		836	
837		838	
839		840	
841		842	
843		844	
845		846	
847		848	
849		850	
851		852	
853		854	
855		856	
857		858	
859		860	
861		862	
863		864	
865		866	
867		868	
869		870	
871		872	
873		874	
875		876	
877		878	
879		880	
881		882	
883		884	
885		886	
887		888	
889		890	
891		892	
893		894	
895		896	
897		898	
899		900	
901			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03805

FOR STATE  
HEALTH DEPT.

3857

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Talbot</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 EASTON</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>325 N. Washington St</b>		d. STREET ADDRESS <b>same</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HOWARD</b>	First <b>H</b>	Middle <b>BARNE</b>	Last <b>STREETS</b>
4. DATE OF DEATH 3	Month	Day <b>4</b>	Year <b>1960</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 24, 1883</b>
9. AGE (In years last birthday) <b>76 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>VFW - Club</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>A.S.</b>	
13. FATHER'S NAME <b>EDWARD STREETS</b>		14. MOTHER'S MAIDEN NAME <b>MAGGIE-C-SLAUGHTER.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-41-8172</b>	
17. INFORMANT <b>Mrs. Neva Coored</b>		Address <b>Easton Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>			
INTERVAL BETWEEN ONSET AND DEATH			
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stoning the underlying cause lost. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>FOUND DEAD IN BED</b>	
20c. TIME OF INJURY Hour a. m. <b>19</b>	Month, Day, Year p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>EASTON</b> (County) <b>MD</b> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Lewis Shultz</i>	DATE SIGNED <b>3-4-60</b>		
EXAMINER'S NAME (Type) <b>WELTY</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>MAR. 7, 1960</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>SPRING HILL CEM</b>	22d. LOCATION (City, town, or county) <b>EASTON</b> (State) <b>MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marie E. Newson</i>	ADDRESS <b>Easton Md.</b>	24a. REC'D BY REGISTRAR DATE <b>MAR. 9 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

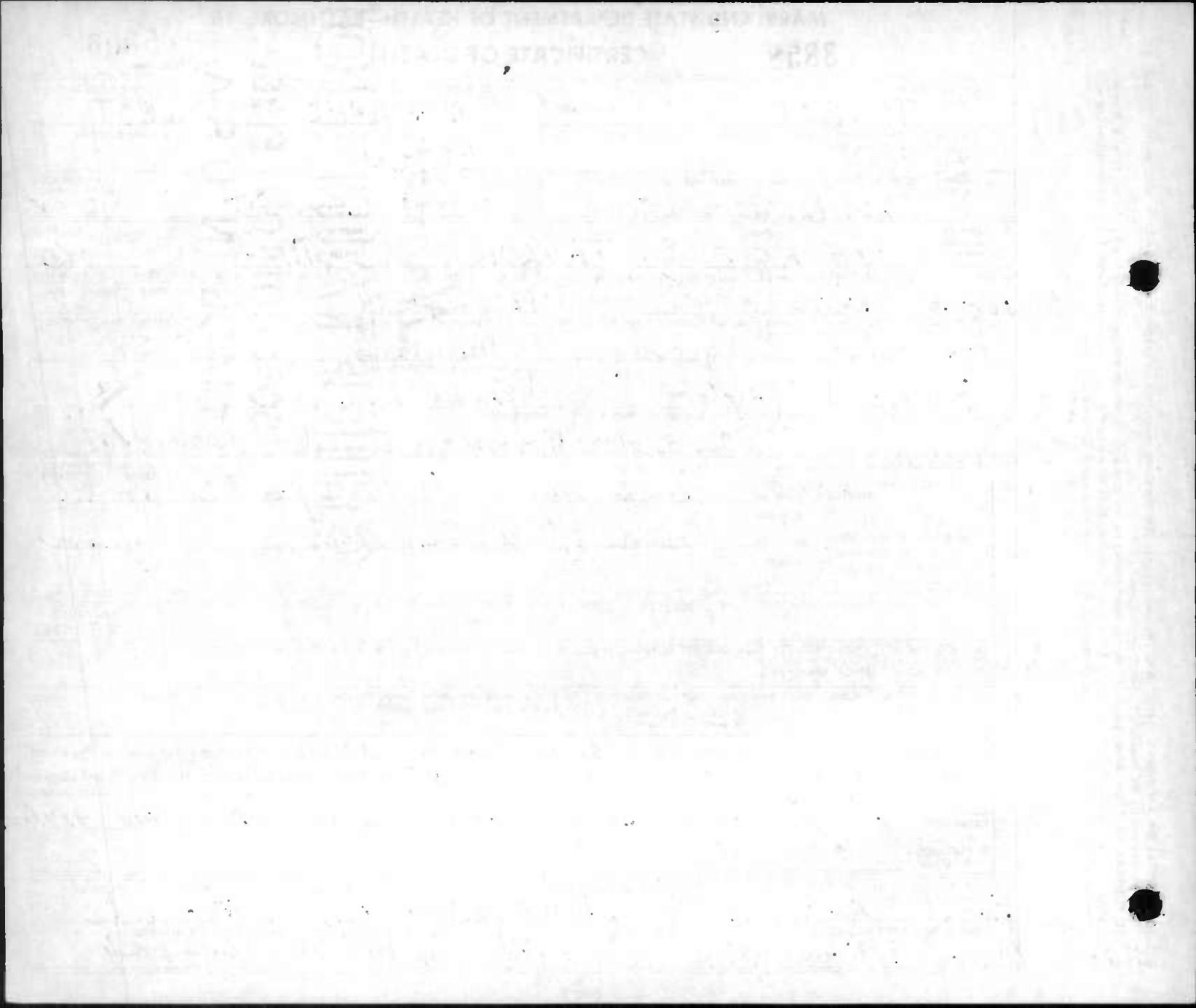
3858

## CERTIFICATE OF DEATH

5006

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>200 N. Aurora St.</b>		e. STREET ADDRESS <b>200 N. Aurora St.</b>	
3. NAME OF DECEASED (Type or print) <b>GEORGE S. TAYLOR</b>		First	Middle
		Last	4. DATE OF DEATH <b>MAR. 31, 1960</b>
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <b>DEC. 26, 1894</b>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>65 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>grocery</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Rubin J. Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Anna L. Warrington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>220-32-1023</b>	
		INFORMANT <b>Mrs. George J. Taylor</b>	
		Address <b>Easton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO <b>Coronary arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>acute years</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Easton</b> (County) <b>Md.</b> (State) <b>MD</b>	
21. I certify that I attended the deceased from <b>3/31, 1960</b> , to <b>3/31, 1960</b> , that I last saw the deceased alive on <b>3/31, 1960</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. J. Ebdon</b>		ADDRESS (Street, city or town, state) <b>12 N. Hansen, EASTON, MD</b>	
PHYSICIAN'S NAME (Type) <b>Maurice E. Newman</b>		DATE SIGNED <b>4/4/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 4, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>EASTON, Maryland</b> (State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newman</b>		24a. REC'D BY REGISTRAR <b>APR 6 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trahan</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3859

## CERTIFICATE OF DEATH

15067

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton Memorial Hosp</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mr. Herman Frederick Thom</b>	First	Middle	Last
4. DATE OF DEATH <b>3 - 18 - 1960</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 18, 1874</b>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>85 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>ret.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>ukn</b>	14. MOTHER'S MAIDEN NAME <b>ukn</b>	Address <b>Paul Thom, Crofton Ave, Baltimore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>none</b>	INFORMANT <b>Paul Thom, Crofton Ave, Baltimore</b>	INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446x</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Arterio-arteritis nephrosclerosis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pneumonia &amp; lower cold</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Easton</b> (County) <b>Md.</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E.C.H. Schmidt</b>	ADDRESS (Street, city or town, state) <b>2195 W. 257 1/2 St. 18560</b>		
PHYSICIAN'S NAME (Type) <b>E.C.H. Schmidt</b>	DATE SIGNED <b>1/21/60</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/21/60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Six Mile Cemetery</b>	22d. LOCATION (City, town, or county) <b>Easton</b> (State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Frangione Carroll</b>	ADDRESS <b>EASTON, MD.</b>	24a. REC'D BY REGISTRAR <b>Mar 19 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

446X

1  
FOR STATE  
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be filed as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3860

03896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hol Easton</b>		d. STREET ADDRESS <b>108 Hammond</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>108 Hammond st</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>MARGARET</b>		First	Middle	Lost		4. DATE OF DEATH <b>Thomas</b>	Month <b>March</b>		
5. SEX <b>F</b>		6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 17, 1954</b>		9. AGE (in years for birthday) <b>3</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>X X</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>X X</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>					
13. FATHER'S NAME <b>Lorvin Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Laura Mills</b>		Address <b>Laura Mills Easton, Md.</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation in burning home</b>			
916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>DUE TO</b>		(b) <b>DUE TO</b>		(c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Home burned - trapped = asphyxiation</b>		20c. TIME OF INJURY Month, Day, Year <b>3-4 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	
20f. (City or town) <b>Easton Tal</b>		(County) <b>md.</b>		(State) <b>md.</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Lewis Shultz</b>		EXAMINER'S NAME (Type) <b>WELTY</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3-8-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/9/60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Richards Cem</b>		22d. LOCATION (City, town, or county) <b>Easton</b>		(State) <b>md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James D. Daubell, Easton, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Arthur S. Evans</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			
VS. ATSM 5M 2/57				DATE <b>MAR 10 '60</b>					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03807

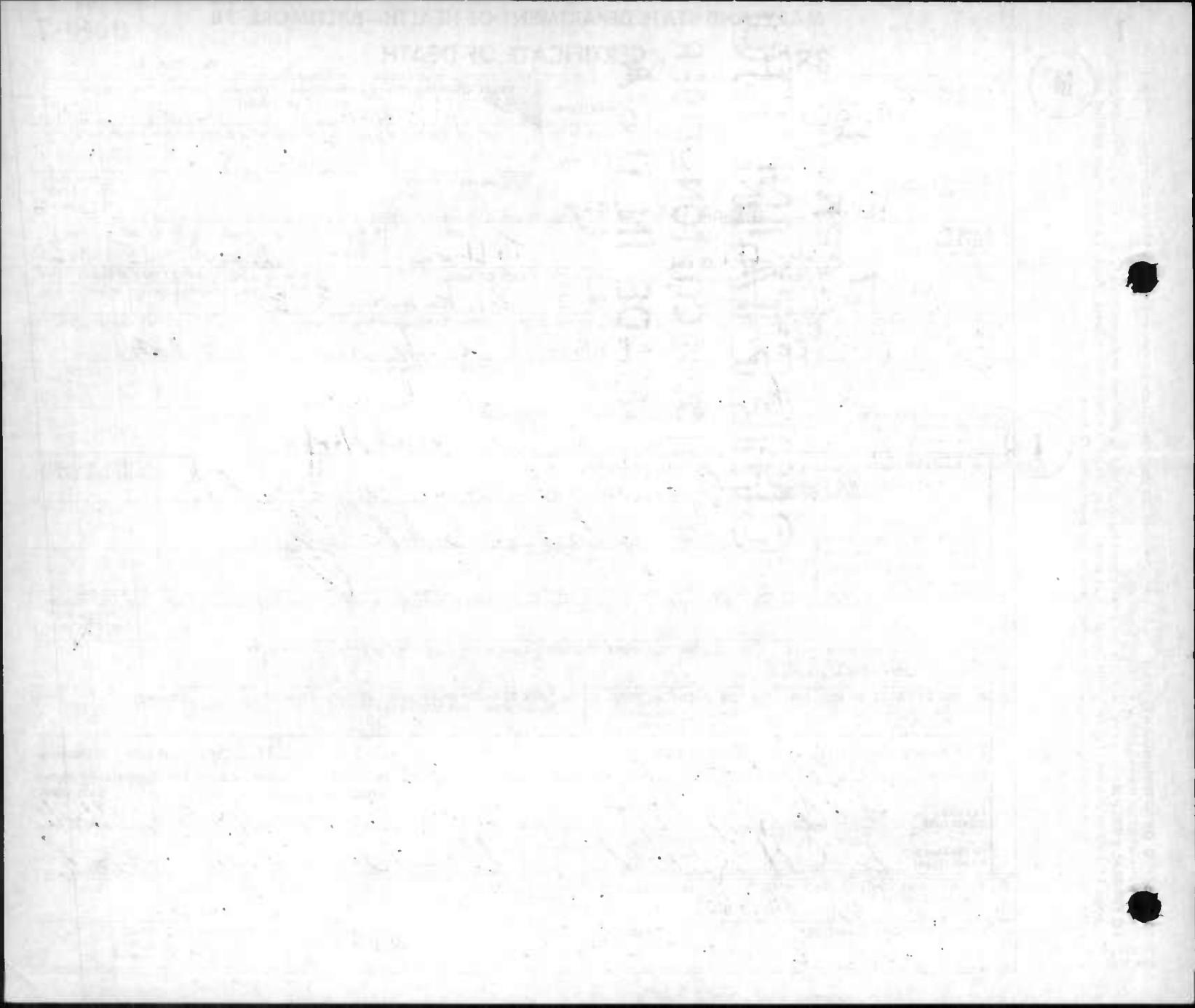
3861

## CERTIFICATE OF DEATH

Reg. Dist. No.

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		M		2		I		2		1									
PLACE OF DEATH		USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		3. NAME OF DECEASED		4. DATE OF DEATH		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
a. COUNTY TALBOT		a. STATE MARYLAND		First WILLIAM		Last TILLER		Month March		Day 15, 1960									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN lb 21 hrs, 15 min.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		d. STREET ADDRESS 05X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
5. SEX M		6. COLOR OR RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown		9. AGE (In years lost birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM LIFESAYER		11. KIND OF BUSINESS OR INDUSTRY FARMING		12. CITIZEN OF WHAT COUNTRY? USA					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM LIFESAYER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —		INFORMANT Memorial Hosp.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO 455X		Bronchopneumonia, right lung Gangrene right leg.		INTERVAL BETWEEN ONSET AND DEATH		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore		(State) Maryland					
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 8:45 M, from the causes and on the date stated above.		ACTUAL SIGNATURE E. C. H. Schmidt		ADDRESS (Street, city or town, state) 2195 Washington St 15 Mar 60		DATE SIGNED E. C. H. Schmidt													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 19, 1960		22c. NAME OF CEMETERY OR CREMATORIAL Denton		22d. LOCATION (City, town, or county) Denton		(State) Maryland											
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thrall		ADDRESS 101 High Avenue Denton		24a. REC'D. BY REGISTRAR MAR 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thrall													



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3852

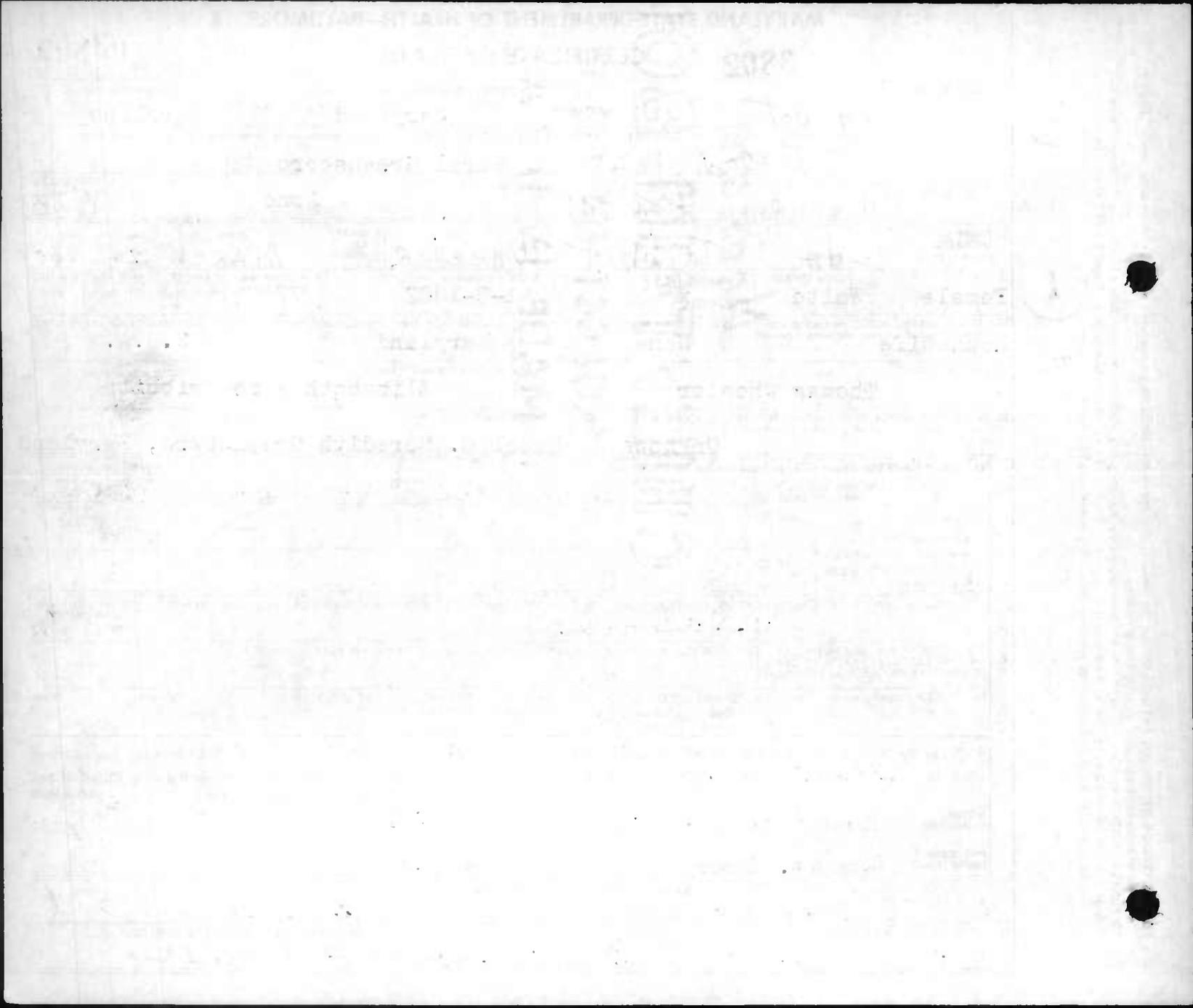
## CERTIFICATE OF DEATH

Reg. Dist. No.

03899

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Talbot</i>		a. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<i>EASTON</i>		10 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Memorial Hospital</i>		d. STREET ADDRESS <i>None</i>	
e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
f. FIRST MIDDLE LAST		4. DATE OF DEATH	
First <i>Eda</i> Middle <i>Tribbitt</i> Last <i>Wheeler</i>		Month <i>MARCH</i> Day <i>24</i> Year <i>1960</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-9-1882</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
Housewife		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Thomas Wheeler</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Anne Tribbitt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Mabel C. Meredith</i>		Address <i>Greensboro, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO <i>420.1</i>		10 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Easton</i> (County) <i>Maryland</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>3/14</i> , 19 <i>60</i> , to <i>3/24</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>3/24</i> , 19 <i>60</i> , and that death occurred at <i>12:30</i> p.m., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Easton, Maryland</i> DATE SIGNED <i>3/25/60</i>	
ACTUAL SIGNATURE <i>Robert W. Trever</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Greensboro</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22d. LOCATION (City, town, or county) <i>Greensboro Md</i> (State) <i>Md.</i>	
22b. DATE THEREOF <i>3-27-60</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 28 '60</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Boulaia</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN:  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3863

## CERTIFICATE OF DEATH

Reg. Dist. No.

03810

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral-director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	c. LENGTH OF STAY IN 1b <i>8 days.</i>	b. COUNTY <i>Talbot</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 Easton</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>	d. STREET ADDRESS <i>1 David Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>James H. White</i>	First <i>James</i>	Middle <i>Hall</i>	Last <i>White</i>
4. DATE OF DEATH <i>March 9 1960</i>	Month <i>March</i>	Day <i>9</i>	Year <i>1960</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 7 1875</i>
9. AGE (In years lost birthday) yrs. <i>84</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired R.R. Postman</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>James F. White</i>	14. MOTHER'S MAIDEN NAME <i>Ella Leonard</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>700-00-0000</i>	INFORMANT <i>Willie White</i>	Address <i>Baltimore Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration pneumonia</i> DUE TO <i>322.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Chronic alcoholism with severe</i> (c) <i>peripheral neuropathy</i> INTERVAL BETWEEN ONSET AND DEATH <i>9 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3/11/60</i> , 19 <i>60</i> , to <i>3/9/60</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>3/9/60</i> , 19 <i>60</i> , and that death occurred at <i>655 P.M.</i> from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>EASTON MD</i>		
ACTUAL SIGNATURE <i>Robert W. Trever</i>	DATE SIGNED <i>3/10/60</i>		
PHYSICIAN'S NAME (Type) <i>Dr. Robert W. Trever</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		
22b. DATE THEREOF <i>March 19 1960</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cypress Cemetery</i>	22d. LOCATION (City, town, or county) <i>Oriole</i>	(State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Black</i>	ADDRESS <i>Easton Md</i>	24a. REC'D BY REGISTRAR DATE <i>MAR 15 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

ESTATE OF MARGARET MCKEEGAN

MARCH 20, 1972 6:00

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3870

## CERTIFICATE OF DEATH

Reg. Dist. No.

03811

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO MEDICAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Talbot</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural St. Michaels</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>40 Easton</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rio Vista Nursing Home</b>		d. STREET ADDRESS <b>Harrison St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>CHARLES PERCY WYATT</b>		First	Middle	Last	4. DATE OF DEATH Month <b>March</b>	Day <b>27,</b>	Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>April 11, 1873</b>	9. AGE (In years last birthday) <b>86 yrs.</b>	IF UNDER 1 YEAR Months <b>86</b>	IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Penna. Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>John H. Wyatt</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelmina Alice (unknown)</b>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerotic cardio vas. d.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>cerebral vascular accident-thromboses - 12 days.</b>		20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>olive on 3-27-60, at 5 P.M., from the causes and on the date stated above.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>19</b>	Day <b>19</b>	Year <b>60</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>St. Michaels, Md.</b>	20f. (City or town) <b>St. Michaels, Md.</b>	(County) <b>St. Michaels, Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>3-22-60</b> to <b>3-27-60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>3-27-60</b> , and that death occurred at <b>5 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>St. Michaels, Md. 3-29-60</b>								
ACTUAL SIGNATURE <b>Guy M. Reeser Jr.</b>		M.D.		DATE SIGNED <b>3-29-60</b>				
PHYSICIAN'S NAME (Type) <b>Dr. Guy M. Reeser, Jr.</b>		St. Michaels, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 30, 1960</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Easton, Maryland</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>		ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR, APR 1 60 <b>Critus S. Thomas</b>		24b. REGISTRAR'S SIGNATURE		

Digitized by srujanika@gmail.com

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3864 Item 14 FilmG261 4-22-60 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

15613

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE						
<i>Talbot</i>		<i>MARYLAND</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY						
<i>Easton</i>	<i>3 days</i>	<i>MARYLAND</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Rural - Longwoods</i>							
<i>Memorial Hospital</i>	d. STREET ADDRESS							
3. NAME OF DECEASED (Type or print)	First <i>Harry</i>	Middle <i>A</i>	Last <i>Ziegler</i>					
4. DATE OF DEATH	Month <i>March</i>	Day <i>21</i>	Year <i>1960</i>					
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH					
<i>MALE</i>	<i>WHITE</i>	<i>WIDOWED</i> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>FEB. 6, 1884</i>					
9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?					
<i>96 yrs.</i>	<i>FARMING</i>	<i>Penna.</i>	<i>U. S. A.</i>					
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME							
<i>JACOB ZIEGLER</i>	<i>Unknown</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	INFORMANT	Address					
<i>No</i>	<i>None</i>	<i>W.K. Mrs. CATHERINE ZIEGLER</i>	<i>Longwoods, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								
<i>Cerebral Infarction, right</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO (b) <i>Thrombosis anterior cerebralis</i>								
DUE TO (c) <i>Paralysis</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>alive</i> on <i>19</i> , to <i>19</i> , and that death occurred at <i>6:40 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>				M.D. <i>219 S. West Street, Baltimore, Maryland.</i>				
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/24/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Woodlawn Cemetery</i>	22d. LOCATION (City, town, or county) <i>Easton, Md.</i>		(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>D. Clayton Cull, Easton</i>		ADDRESS <i>Ms.</i>		24a. REC'D BY REGISTRAR <i>APR 19 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

332x